MEDICAID PROVIDER MANUAL OVERVIEW

SECTION 1 – INTRODUCTION

The following documents comprise the Michigan Medicaid Provider Manual and address all health insurance programs administered by the Michigan Department of Health and Human Services (MDHHS). MDHHS also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)

1.1 ORGANIZATION [CHANGE MADE 7/1/2025]

The following table identifies each chapter and appendix in the manual, indicates what providers are affected, and provides a brief overview of each.

Chapter Title	Affected Providers	Chapter Content
General Provider Chapters		
Medicaid Provider Manual Overview	All Providers	Brief discussion of the organization of the manual and effectively using the document.
General Information for Providers	All Providers	Policies and general information regarding provider enrollment and participation, prior authorization, record retention, billing the beneficiary, fraud and abuse, etc.
Beneficiary Eligibility	All Providers	Policies and information regarding how to verify beneficiary eligibility, information on various eligibility categories, enrollment in contracted health plans, beneficiary utilization control, etc.
Coordination of Benefit	All Providers	Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.
Billing & Reimbursement for Dental Providers	Providers billing the ADA **(text deleted 7/1/2025)** or 837 Dental claim formats.	Policies and instructions for billing dental services.
Billing & Reimbursement for Institutional Providers	Providers billing the UB-04 or 837 Institutional claim formats.	Policies and instructions for billing institutional services.

Chapter Title	Affected Providers	Chapter Content
Billing & Reimbursement for Professionals	Providers billing the CMS-1500 or 837 Professional claim formats.	Policies and instructions for billing professional services.
Electronic Visit Verification	MI Choice Waiver Agencies, Centers for Independent Living, Integrated Care Organizations (ICOs), Home Help Agency Providers and Individual Caregivers, Prepaid Inpatient Health Plans (PIHPs), Home Health Agencies, Medicaid Health Plans, Community Mental Health Services Programs (CMHSPs)	Information for personal care services (PCS) and home health care services (HHCS) providers of the 21st Century Cures Act requirements for using Electronic Visit Verification (EVV).
Provider/Service Specific Chapters		
Ambulance	Ambulance	Coverage policy related to emergency and non-emergency transports by ground, water or air ambulance.
Ambulatory Surgical Centers	Ambulatory Surgical Centers	Information regarding billing, coverage, and reimbursement policies related to Ambulatory Surgical Centers.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Mental Health and Substance Abuse providers, Fee for Service – Psychologists, Social Workers, Counselors and Marriage and Family Therapists	Coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans. Includes Children's Home and Community Based Services Waiver, Substance Abuse, and Habilitation Supports Waiver information. Includes Fee for Service Non-Physician Behavioral Health.
Brain Injury Services	Brain Injury Services providers, Hospitals, Practitioners, Nursing Facilities	Coverage policy related to services provided by Brain Injury Services.
Children's Special Health Care Services	All Providers	Information regarding program eligibility, benefit package, etc.
Chiropractor	Chiropractor	Coverage policy related to chiropractic services.

Chapter Title	Affected Providers	Chapter Content
Community Health Worker Services	MI Medicaid certified Community Health Workers (CHWs)	Provider enrollment requirements, covered services, and billing and reimbursement considerations.
Community Transition Services	Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations	Policy requirements for operations and billing for Community Transition Services
Dental	Dental Providers/Dental Clinics	Coverage policy related to dental services and information on the ***Healthy Kids Dental*** Program.
Doula Services	MDHHS-registered Doulas	Provider enrollment requirements, covered services, and reimbursement considerations.
Early and Periodic Screening, Diagnosis and Treatment	All Providers	Coverage policy for Medicaid beneficiaries younger than 21 years of age.
Emergency Services Only Medicaid	All Providers	Information regarding program eligibility, benefit package, etc.
Family Planning Clinics	Title X Clinics	Coverage policy related to family planning services provided through Title X clinics.
Federally Qualified Health Centers	Clinics designated by the U.S. Department of Health & Human Services (HHS) as FQHCs	Coverage and reimbursement policies applicable to FQHCs.
Healthy Michigan Plan	All Providers	Information regarding program eligibility, benefit package, healthy behaviors, cost sharing, etc.
Hearing Services and Devices	Audiologists, Hearing Centers, Hearing Aid Dealers, Speech-Language Pathologists	Coverage and reimbursement policies related to hearing services, therapy, devices, and supplies.
Home and Community Based Services	Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs), and Waiver Agencies	Coverage policy related to the requirements for Home and Community-Based Services (HCBS)

Chapter Title	Affected Providers	Chapter Content
Home Health	Home Health	Coverage policy related to services provided by home health agencies.
Home Help	Home Help providers	Coverage policy related to services provided by Home Help providers. Also includes information regarding program eligibility, services, and service limits.
Hospice	Hospice, Medical Suppliers	Coverage policy related to hospice services.
Hospital	Inpatient & outpatient hospitals	Coverage policy for inpatient and outpatient hospital services. Also includes cost reporting requirements, Graduate Medical Education and disproportionate share payment methodologies, appeals, etc.
Independent Diagnostic Testing Facilities and Portable X-ray Suppliers	Independent Diagnostic Testing Facilities and Portable X-ray Suppliers	Information regarding enrollment, billing, coverage and reimbursement for Independent Diagnostic Testing Facilities and Portable X-ray Suppliers.
Laboratory	Providers of laboratory tests and services	Coverage, billing, and reimbursement policies related to laboratory tests and services.
Local Health Departments	Local Health Departments	Coverage policy, cost reporting requirements, interim payments, and appeals for local health departments.
Maternal Infant Health Program	Certified MIHP providers	Provider certification requirements, beneficiary eligibility criteria, and covered services.
Maternity Outpatient Medical Services	Providers of Maternity Related Services	Program eligibility requirements, benefit package, and billing instructions.
Medicaid Health Plans	Contracted HMOs	Health plan participation and coverage policies.
Medical Supplier	Medical Suppliers/Durable Medical Equipment, Orthotists/Prosthetists	Coverage policies and parameters for medical supplies, durable medical equipment, orthotics, and prosthetics.
MI Choice Waiver	All Providers	Information regarding program eligibility, benefit package, etc.

Chapter Title	Affected Providers	Chapter Content
MI Health Link	Integrated Care Organizations and related providers	Describes the MI Health Link program which integrates Medicare and Medicaid benefits into one coordinated delivery system.
Non-Emergency Medical Transportation	Non-Emergency Transportation Providers and Authorizing Parties	Coverage policy related to scheduled non-emergency, non-ambulance, medical transportation.
Nursing Facility	Nursing Facilities, Medical Suppliers	Coverage policy; certification, survey and enforcement policy; cost reporting and reimbursement methodology.
Nursing Facility Level of Care Determination	Nursing Facilities, MI Choice Waiver Program, Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link HCBS Waiver Program	Policies, processes, and criteria for Nursing Facility Level of Care Determination, Informed Choice, and Appeals
Pharmacy	Pharmacies	Coverage policy related to pharmacy services.
Plan First Family Planning	All Providers	Program eligibility requirements, benefit package, and billing instructions.
Practitioner	MD, DO, Oral-Maxillofacial Surgeons, DPM, PA, NP, CRNA, AA, CNM, Physical Therapists, Medical Suppliers	Coverage policy related to practitioner services.
Private Duty Nursing	Independent & PDN Agency	Coverage policy related to private duty nursing services provided through an agency or by an independent nurse.
Program of All Inclusive Care for the Elderly (PACE)	Contracted PACE providers	Information regarding program eligibility, benefit package, etc.
Rural Health Clinics	Rural Health Clinics	Coverage policy related to Rural Health Clinics.
School Services Program	Enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf	Coverage policy for medical services provided to Medicaid eligible students.

Chapter Title	Affected Providers	Chapter Content
School Services Program Administrative Outreach Program Claims Development	Enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf	Coverage, claiming, and billing policies related to the School Services Program Administrative Outreach Program.
School Services Program Random Moment Time Study	Enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf	Random moment time study process for the School Services Program Direct Medical Services program.
Special Programs	All Providers	General information about MDHHS health insurance programs that are not addressed elsewhere in this manual.
Telemedicine	Practitioners, Hospitals, Nursing Facilities, Federally Qualified Health Centers (FQHC), Local Health Departments (LHD), Rural Health Clinics (RHC), Community Mental Health Services Programs (CMHSP), Tribal Health Centers (THC), School Services Program (SSP) Providers, Dentists, Dental Clinics, Dental Health Plans, Hearing Aid Dealers, Cochlear Implant Manufacturers, Audiologists/Hearing Centers, Vision Providers	Coverage policy related to telemedicine services.
Therapy Services	Therapy Providers, Medical Suppliers	Therapy provider participation requirements and coverage policy.
Tribal Health Centers	Tribal Health Centers	Coverage policy for Tribal Health Centers, defined under the Indian Self-Determination and Education Assistance Act (Public Law 93-638 as those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).

Chapter Title	Affected Providers	Chapter Content
Urgent Care Centers	All Providers	Information regarding billing, coverage, and reimbursement policies related to Urgent Care Centers.
Vision	Ophthalmologists, Optometrists, Vision suppliers	Coverage policy for vision services and hardware.
Appendices		
Acronyms	All Providers	
Directory	All Providers	
Glossary	All Providers	
Forms	All Providers	Provides samples of forms identified in the manual and instructions for form completion, when appropriate. Providers may also download forms directly from the MDHHS website.

1.2 PRINTING

MDHHS does not provide a printed copy of the Provider Manual but does provide the information via compact disc (CD) to enrolled providers upon request. (Refer to the Manual Updates Section of this chapter for additional information.)

Should the user elect to print portions of the manual for their use, please note the following:

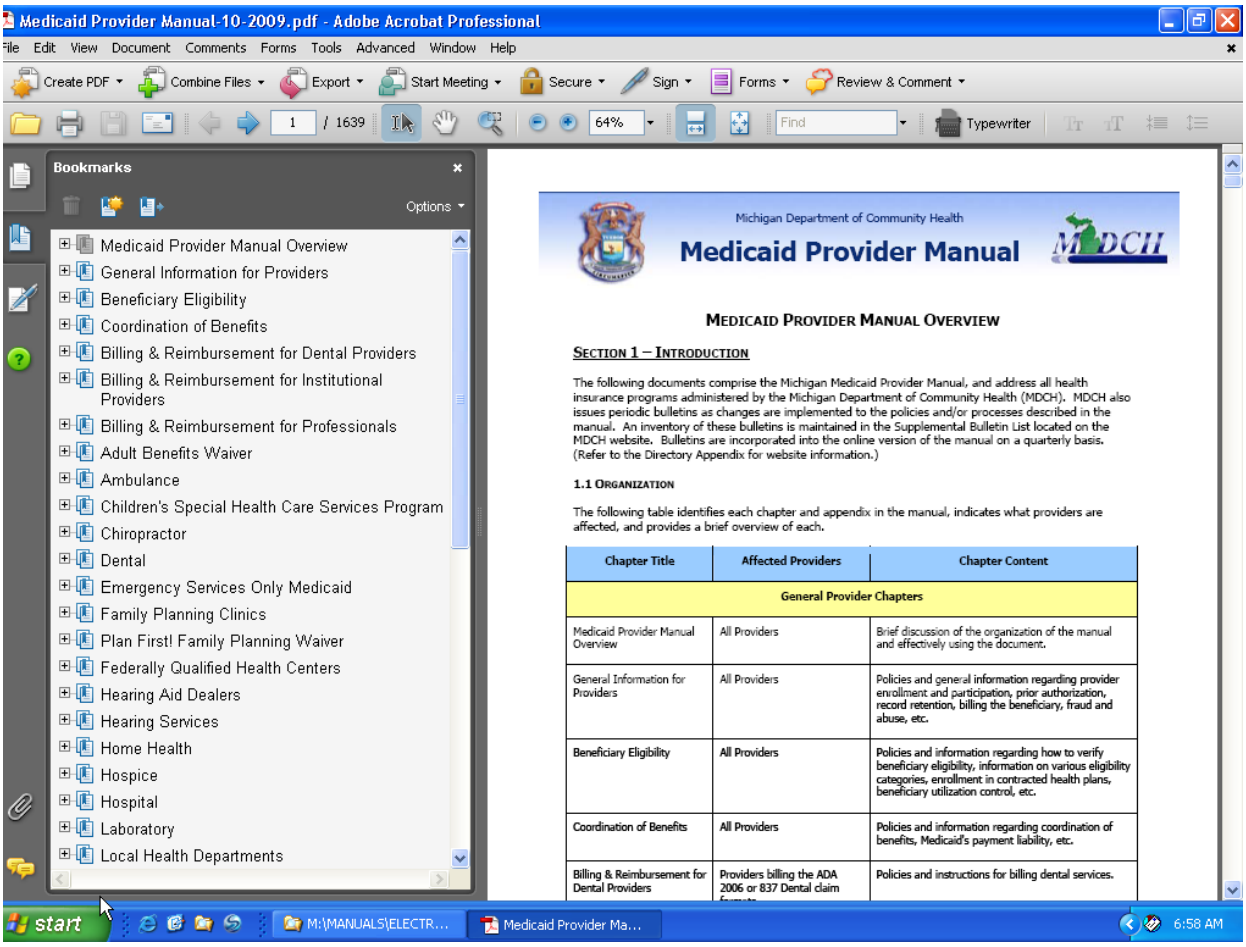
- The version date is noted at the bottom of each page on the left hand side. When researching policy, it is imperative that the most current version be used.
- The page number at the bottom right hand side of each page represents the page number within that chapter, not within the whole document.
- The name of the chapter is on the bottom of each page.
- It is recommended that any printing be done in black and white, not color, as printing in color can be very expensive. The features on each page are adequately effective in black and white.

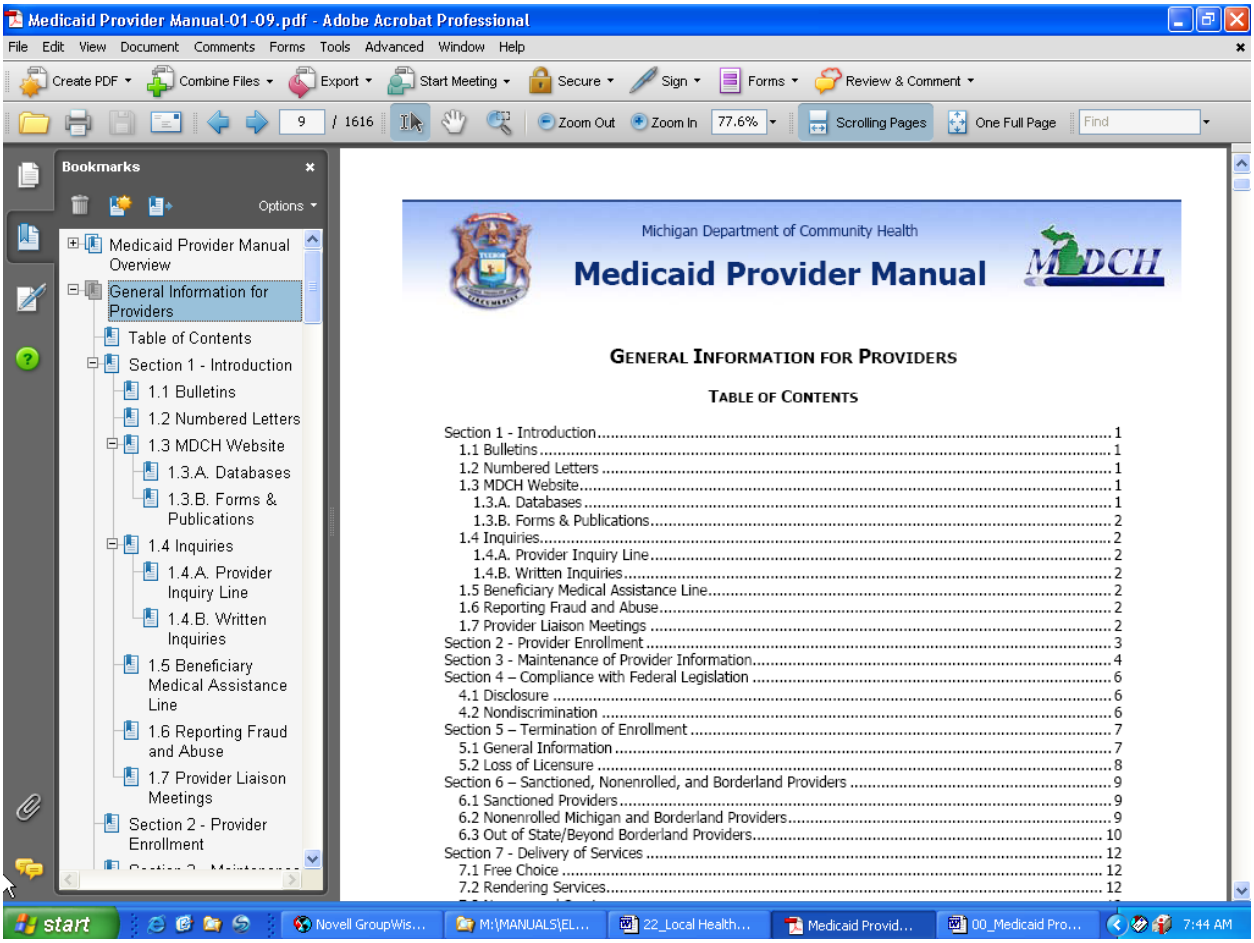
SECTION 2 - NAVIGATION THROUGH THE MANUAL

2.1 BROWSE CAPABILITIES

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation keys located on a palette on the left side of the screen. (See the following illustrations.) To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic. The bookmarks in the manual correspond to chapter titles, section titles, subsections and appendices.

Bookmarks can be expanded or collapsed to easily link to the desired information. Primary headings, such as chapter titles, display as the first level of bookmarks. If a primary heading has secondary headings (i.e., section titles, subsections), they are displayed underneath the primary heading. Primary headings can be collapsed to hide the secondary headings. When a primary heading is collapsed, it has a plus (+) sign next to it. Click on the plus (+) sign to expand the bookmarks to display secondary headings. When all headings are displayed, a minus (-) sign appears next to the heading. (See the illustrations below.)





Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

2.2 SEARCH CAPABILITIES

Users can access the powerful online search capabilities of Adobe Acrobat to quickly locate information within the manual. There are two search methods:

- Click on Edit, Find on the tool bar and enter a keyword in the Find dialog box, or
- Click on the Binoculars on the toolbar and enter a keyword in the dialog box.

Always use the most specific term or acronym for the search, rather than a general term. (Refer to the Acronym Appendix for a list of all those used in the manual.) Start the search on the first page of the manual to assure that all relevant information is located.

In order to locate all of the information pertinent to a subject, search by the acronym if the word or term has one.

SECTION 3 – MANUAL UPDATES

3.1 QUARTERLY UPDATES

The Medicaid Provider Manual located on the MDHHS website is updated quarterly to reflect information that has been added, deleted or changed via policy bulletins and other communications during the previous quarter. The contact information contained in the Directory Appendix is also updated quarterly.

A policy bulletin, detailing the manual changes made each quarter, is sent to all Medicaid-enrolled providers and is communicated by e-mail to those subscribed to the Medicaid ListServ.

A compact disc (CD) version of the Medicaid Provider Manual is available upon request. (Refer to the Directory Appendix for contact information.)

3.2 HISTORIC MANUALS

The current version of the manual is maintained on the MDHHS website. Previous versions of the electronic manual are available back to January 2004. Refer to the Directory Appendix for information on ordering CD versions of the manual.

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SECTION 1 – INTRODUCTION

This chapter applies to all providers.

The Michigan Department of Health and Human Services (MDHHS) acts as the fiscal intermediary for several health insurance programs including, but not limited to, Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS), Plan First Family Planning, and the Repatriate Program. Although coverage, limitations, and administration may differ, billing procedures and reimbursement methods are essentially the same.

This chapter is used for all health insurance programs administered by MDHHS. Any reference to Medicaid in the manual and bulletins pertains to all programs administered by MDHHS unless specifically stated otherwise. Reference to the state mental health facilities includes only those facilities owned and operated by MDHHS. It does not include proprietary facilities for the mentally ill or developmentally disabled.

1.1 BULLETINS

This manual is the provider's primary source of policy information. Revisions to the manual regarding policy and procedural changes are communicated to the provider via Policy Bulletins. Providers affected by a bulletin should retain it until it is incorporated into the online version of the manual unless instructed otherwise. Bulletins are numbered for the provider's reference. The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04).

Bulletins are distributed to affected providers by U.S. mail or e-mail. Providers are expected to maintain current contact information in CHAMPS for timely notification. Bulletins are also posted on the MDHHS website. (Refer to the Directory Appendix for website and contact information.)

1.2 NUMBERED LETTERS

The purpose of a numbered letter is to educate, inform, and/or clarify issues related to MDHHS policies, procedures, and/or decisions that affect multiple providers.

1.3 FILE TRANSFER

The MDHHS–File Transfer application allows for the secure electronic transfer of files between MDHHS and Medicaid providers, Medicaid Health Plans, and other organizations. This application is a front-end interface for secure file transfer protocol (FTP) functionality, is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant, and uses 128-bit encryption. File types for transfer include, but are not limited to, Medicaid cost report software, Medicaid filed cost reports, Medicaid filed reconciliation reports, and claim and encounter files containing protected health information.

All users requesting access to the MDHHS–File Transfer application must have their own unique MILogin user identification (ID) and password, and the user ID and password must not be shared. Each approved user must be authorized to view any sensitive data that may be transmitted.

MDHHS program areas that use the MDHHS–File Transfer application to securely communicate with providers are authorized to limit the number of users per organization. MDHHS may contact the requestor directly to collect additional information regarding the users that will be applying, the area type(s) they need access to (shared and/or provider specific), and when user access should be removed. MDHHS is not responsible for communications that are undeliverable or are otherwise not received due to a provider's or authorized user's failure to maintain or provide accurate information.

MDHHS-File Transfer is accessed through MILogin. Refer to the Directory Appendix for website information.

1.4 ListServ Communications

The MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) offers individuals the option of receiving automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.) through subscription to an e-mail listserv. Subscription instructions are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.5 MDHHS Website

The MDHHS website provides electronic access to the Medicaid Provider Manual, policy bulletins, proposed policy issued for public comment, as well as a variety of other valuable provider information and resources. (Refer to the Directory Appendix for website information.)

1.5.A. Additional Code/Coverage Resource Materials

MDHHS maintains procedure/revenue code fee information in a series of website databases and professional fee schedules. These list procedure codes, descriptions, and fee screens. This information is updated as changes in coverage and/or fees are implemented. Databases and fee schedules are only available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Additional pertinent coverage parameters, such as documentation and billing indicators, are accessible via the Medicaid Code and Rate Reference tool. Medicaid Code and Rate Reference is an online code inquiry system that provides real-time information for the following:

- Age restrictions;
- Documentation requirements;
- Prior authorizations, and medical conditions that may bypass these requirements;
- Service frequency limitations; and
- Rate information.

(Refer to the Directory Appendix for website information.)

1.5.B. Forms & Publications

In an effort to reduce the administrative burden on providers, forms required by Medicaid are available for electronic download from the MDHHS website. Many publications regarding MDHHS programs and resources are also available.

1.5.C. Disclaimer

The Medicaid Provider Manual serves as the policy reference guide and will supersede any discrepancies regarding rates or coverage on the website, databases, fee schedules, or Medicaid Code and Rate Reference tool.

1.6 Inquiries

MDHHS has several methods of resolving inquiries. Questions regarding policies and procedures should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.6.A. Provider Inquiry Line

If billing assistance is required, the Provider Inquiry Line is available for immediate resolution of inquiries. (Refer to the Directory Appendix for contact information.)

1.6.B. Written Inquiries

Complex problems may require research and analysis. The problem should be clearly explained, in writing, with complete documentation (e.g., RA) attached and sent to Provider Inquiry.

1.7 Beneficiary Medical Assistance Line

If assistance to the beneficiary is required, the Beneficiary Helpline is available to assist them. (Refer to the Directory Appendix for contact information.) Beneficiaries enrolled in a Medicaid Health Plan (MHP) should be referred to their plan for assistance. Plan member services contact information is included on the beneficiary's plan membership card.

1.8 Reporting Fraud and Abuse

Any provider, beneficiary, or employee who suspects Medicaid fraud or abuse is encouraged to report that information to MDHHS. Information about fraud and abuse reporting requirements is located on the MDHHS website. (Refer to the Directory Appendix for website and contact information.)

1.9 Provider Liaison Meetings

MDHHS routinely schedules meetings to meet with provider specialty groups (e.g., physicians, hospitals, pharmacies, etc.) to discuss issues of interest/concern. The meetings are arranged through the various provider professional associations, though all affected providers and interested parties are welcome to attend. A calendar of most provider liaison meetings is posted on the MDHHS website, along with contact information. A calendar of Pharmacy Liaison meetings is posted on the MDHHS Pharmacy Benefits Manager website. (Refer to the Directory Appendix for website and contact information.)

1.10 Claims Processing System

The Community Health Automated Medicaid Processing System (CHAMPS) is the web-based MDHHS Medicaid claims processing system. CHAMPS is comprised of the following subsystems: Provider Enrollment (PE), Eligibility and Enrollment (EE), Prior Authorization (PA), Claims and Encounters (CE), and Contracts Management (CM). This web-based system allows for the following functions to be completed online: provider enrollment, provider updates, claims status, direct claim entry, batch claim submission, claim adjustments/voids, payment status, prior authorization, eligibility verification, member search and ordering/referring provider verification. (Refer to the Directory Appendix for contact and website information.)

SECTION 2 - PROVIDER ENROLLMENT

Consistent with 42 CFR 431.51(c)(2), 42 CFR 455.452, and pursuant to Michigan's Social Welfare Act (Public Act 280 of 1939 [MCL 400.111e]), the Medicaid single state agency is required , and has the authority, to set reasonable standards and screening related to the qualifications of providers, and may define exclusions that the Medicaid Director determines necessary to protect the best interests of the program and its beneficiaries. An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction or exclusion, is a valid provider type in CHAMPS, and whose services are directly reimbursable per MDHHS policy may enroll as a Medicaid provider. Out-of-state providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Beyond-Borderland Area subsection of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDHHS.

MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States. Any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid.

The following disclosing individuals are also required to be screened as part of the provider's enrollment:

- An individual with a 5% or greater direct or indirect ownership interest in the provider. This requirement pertains to individuals as well as groups of individuals;
- An agent. An agent is any person who has been delegated the authority to obligate or act on behalf of a provider such as a fiduciary agent or contractor;
- An individual who is on the Board of Directors of a provider entity. A Board of Directors is a group of individuals who are selected or elected to establish corporate management-related policies and to make decisions on major company issues; or
- An individual who is a managing employee. A managing employee would be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.

Providers must have their enrollment approved through the on-line MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid Fee-for-Service beneficiaries. Refer to the Directory Appendix for contact information related to the online application process, including a CHAMPS Preparation Checklist of required information.

A provider's participation in Medicaid will be effective on the date the provider's on-line application is submitted, or a provider may request that enrollment be retroactive to a specific date when completing the on-line application. Retroactive enrollment is not considered prior to the effective date of licensure/certification. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.

All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDHHS. MDHHS will notify providers when revalidation is required. Providers must notify MDHHS within 35 days of any change to their enrollment information.

Providers must have their social security number (SSN), employer identification, or tax identification number (EIN/TIN) registered with the Michigan Department of Technology, Management & Budget Vendor Registration prior to enrolling with MDHHS.

Providers electing to appoint another person to enter their MDHHS enrollment information in the CHAMPS PE subsystem on their behalf must complete and retain a copy of the MDHHS Provider Electronic Signature Agreement Cover Sheet (MDHHS-5405) and the MDHHS Electronic Signature Agreement (DCH-1401). Both forms must be submitted to the Provider Enrollment Section per instructions provided on the cover sheet. (Refer to the Forms Appendix for a copy of the MDHHS-5405 and the DCH-1401.)

For information regarding substitute physician or a locum tenens arrangement, refer to the Practitioner Chapter of this manual.

A Medicaid Health Plan (MHP) is responsible for reimbursing a contracted provider or subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse noncontracted providers for properly authorized, medically necessary covered services.

2.1 Provider Ownership and Control Disclosures

Provider enrollment information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

2.1.A. Required Disclosure Information

Providers (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation, and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of a corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.

- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employees.

2.1.B. Criminal Offense Notification

Providers must notify the state licensing agency and MDHHS Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.

2.1.C. Nursing Facility Change of Ownership (CHOW)

When a nursing facility changes ownership, the successive owner can either retain the preceding owner's National Provider Identifier (NPI) or obtain a new NPI. If the successive owner chooses to obtain a new NPI, then they must complete the enrollment process in the Community Health Automated Medicaid Processing System (CHAMPS) and submit the required disclosure information within 35 days of the Centers for Medicare & Medicaid Services (CMS) established effective date of the change in ownership. If the successive owner decides to retain the preceding owner's NPI, then the successive owner cannot do a new enrollment. The successive owner's decision to either retain the NPI or to obtain a new NPI does not impact the automatic assignment of the provider agreement.

2.2 Enrollment Application and Revalidation Fees

Enrollment application and revalidation fees are required from all institutional providers, as defined by the Centers for Medicare & Medicaid Services (CMS). Individual physicians and non-physician practitioners are not considered institutional providers and, as such, are not subject to an application or revalidation fee. Providers who are enrolled in or have paid the application fee to Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP) are not required to pay an application fee to the Michigan Medicaid Program. The fee is required for each enrolled provider type at the time of initial enrollment, re-enrollment and revalidation. The fee amount is established by CMS and updated annually.

2.3 Enrollment Screening

MDHHS conducts Medicaid provider enrollment screening per federal and state rules and regulations.

2.3.A. Provider Categorical Risk Enrollment Screening

2.3.A.1. Categorization of Providers Based on Level of Risk

Provider types must be categorized based on the potential risk of fraud, waste, and abuse to the Medicaid Program. MDHHS has adopted the risk categorization established by the Centers for Medicare & Medicaid Services (CMS). For provider types that are not given a risk level by CMS, MDHHS will be responsible for assigning the appropriate risk level. A provider's categorical risk level may be adjusted to "high" due to payment

suspension, overpayment status, or Health & Human Services – Office of Inspector General (HHS-OIG)/Medicaid Program exclusion status and after lifting of a temporary moratorium.

2.3.A.2. SCREENING ACTIVITIES BASED ON RISK CATEGORY AND PROVIDER TYPE

Additional provider screening activities are required and will be conducted based on the provider's categorical risk level. The following table summarizes the general screening activities by risk category and type of provider.

Category	Type of Provider	Screening Activities
High	▪ Prospective (newly enrolling) home health agencies ▪ Prospective (newly enrolling) DMEPOS suppliers ▪ Skilled nursing facilities (SNFs) [effective January 1, 2023] ▪ Prospective (newly enrolling) Michigan Diabetes Prevention Program (MiDPP) suppliers.	▪ Fingerprint based criminal background checks ▪ Unannounced pre- and post-enrollment site visits ▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, National Provider Identifier (NPI), HHS-OIG exclusion status, and information regarding disclosed individuals
Moderate	▪ Ambulance services ▪ Community Mental Health centers ▪ Comprehensive Outpatient Rehabilitation Facilities (CORFs) ▪ Hospice organizations ▪ Independent clinical laboratories ▪ Physical therapists enrolling as individuals or as group practices ▪ Revalidating home health agencies ▪ Revalidating DMEPOS suppliers ▪ Revalidating skilled nursing facilities (SNFs) ▪ Portable x-ray suppliers	▪ Unannounced pre- and post-enrollment site visits ▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, HHS-OIG exclusion status, and information regarding disclosed individuals ▪ Criminal background check
Limited	▪ All other provider types	▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, HHS-OIG exclusion status, and information regarding disclosed individuals ▪ Criminal background check

2.3.B. Site Inspections

All enrolled providers must permit unannounced on-site inspections as a condition of participation. MDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as "moderate" and "high" categorical risk. (Refer to the Provider Categorical Risk Enrollment Screening subsection within this chapter for further information.)

2.3.C. Criminal Background Checks

All enrolled providers, or any person with a five percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation. MDHHS will conduct criminal background checks and will require submission of fingerprints from providers designated as "high" categorical risk when directed by CMS.

2.3.D. Verification of Provider Information

MDHHS conducts verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, information regarding disclosed individuals, HHS-OIG exclusion status, and other databases, as required.

2.4 Temporary Moratoria

A temporary moratoria, numerical caps, or other limits may be placed on the enrollment of new providers or provider types identified as having a significant potential or increased risk for fraud, waste, or abuse as long as it would not adversely impact beneficiary access to medical assistance.

2.5 Medicare Cost Share Enrollment Type

Billing, rendering, attending, ordering, and referring Medicare providers who only intend to submit claims to Medicaid for reimbursement of Medicare cost-sharing for dual eligible beneficiaries may choose the restricted cost-sharing option, Medicare Cost Share, during CHAMPS enrollment. Medicare provider types not recognized by Medicaid must choose the Medicare Cost Share option. These providers must contact Provider Enrollment for enrollment assistance. (Refer to the Directory Appendix for contact information.) This special enrollment type is only available to providers participating in original Medicare. Providers participating in Medicare Part C, also known as a Medicare Advantage Plan, must complete a full Medicaid enrollment.

SECTION 3 - MAINTENANCE OF PROVIDER INFORMATION

Maintenance of provider information is done through the CHAMPS PE online system. (Refer to the Establishing Provider Access in CHAMPS section for additional information.) Providers must notify MDHHS via the on-line system within 35 days of any change to their enrollment information. (Refer to the Directory Appendix for CHAMPS PE access information.)

Examples of such changes include:

- A change in the provider's Federal Employer ID Number (or Tax ID Number).
- Moving to a new office
- Adding another office or location
- Leaving the current employer/partnership
- Changing the address(es) to which RAs and/or correspondence are sent
- Retiring from practice
- Closing a business
- Provider files Chapter 11, Reorganization
- Provider files Chapter 7, Bankruptcy
- Any action taken by a licensing authority or hospital that affects health care privileges
- Any criminal conviction
- Addition/change of a specialty
- Employer/partnership additions or changes
- Change/loss of licensure status
- New employees/providers
- New contractual obligations to a clinic, employer, contractor, or other entity
- Clinical Laboratory Improvement Amendments (CLIA) changes
- A change in ownership
- Name change
- E-mail address
- Addition/change of information related to the participating or collaborating physician and/or agreements

Providers must contact the Provider Enrollment Unit to change a Pay To address. (Refer to the Directory Appendix for contact information.)

The Provider Enrollment Unit disenrolls providers if postal mail is returned as nondeliverable.

Nursing Facility providers should refer to the Nursing Facility Chapter for additional instructions.

Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

SECTION 4 – ESTABLISHING PROVIDER ACCESS IN CHAMPS

4.1 PROVIDER DOMAINS

Providers must register for a MILogin account to access the CHAMPS system. (Refer to the Directory Appendix for website information.) All users within a provider's organization who need access to information within CHAMPS (Provider Enrollment, Claims, Prior Authorization, etc.) must obtain a MILogin user ID and password. The CHAMPS Provider Enrollment online system allows providers to easily update their information at any time or submit a new provider enrollment application with an approval process of approximately one to two weeks.

The MILogin user who submits the Provider Enrollment application becomes the Provider Domain Administrator for that application. The Provider Domain Administrator has the responsibility of assigning rights for all users within the organization to access the provider's file. Multiple Provider Domain Administrators may be established for a single organization, but a separate application must be completed and approved for each administrator.

4.2 PROVIDER PROFILES

In addition to establishing a provider domain and obtaining necessary user IDs and passwords, the provider must select the appropriate profiles to access applicable subsystems within CHAMPS. The following is a list of available profiles and their definitions.

Profile	Definition
Domain Administrator	The individual who assigns or removes domain and profile access for CHAMPS users
CHAMPS Full Access	Full FFS access to Provider Enrollment, Prior Authorization, Eligibility, and Claims Subsystems
CHAMPS Limited Access	View only access to Provider Enrollment and full FFS access to Prior Authorization, Eligibility, and Claims Subsystems
Prior Authorization Access	FFS access to Prior Authorization only
MCO Provider Access	View Only access to MCO Provider Enrollment
Eligibility Inquiry	Access to Eligibility only
Provider Enrollment Access	Full FFS access to Provider Enrollment only
Provider Enrollment View Access	View Only access to Provider Enrollment
Billing Agent Access	Access to Billing Agent Provider Enrollment only
Claims Access	Access to Claims and Encounters only
Atypical Access	Full access to Provider Enrollment and Electronic Service Verification (ESV)

There are available profiles for Fee for Service (FFS), Managed Care Organization (MCO), and Pharmacy providers along with Billing Agents. Profiles must be established to grant access to each subsystem (Provider Enrollment, Claims, Prior Authorization) within CHAMPS. Users may have multiple profiles if necessary.

Profiles available for each type of provider accessing CHAMPS are as follows:

Provider/Profile	Domain Administrator	CHAMPS Full Access	CHAMPS Limited Access	Prior Authorization Access	MCO Provider Access	Eligibility Inquiry	Provider Enrollment Access	Provider Enrollment View Access	Billing Agent Access	Claims Access
FFS Provider	X	X	X	X		X	X	X		X
MCO Provider	X		X		X	X		X		X
Billing Agent	X						X	X	X	X
Pharmacy	X	X	X			X	X	X		X

Additional information regarding CHAMPS access is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 5 – NONDISCRIMINATION

In accordance with federal regulations, including Section 1557 of the Patient Protection and Affordable Care Act, an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964, 42 USC 2000d et seq. (race, color, national origin), Title IX of the Education Amendments of 1972, 20 USC 1681 et seq. (sex, gender identification, sexual orientation), the Age Discrimination Act of 1975, 42 USC 6101 et seq. (age), or Section 504 of the Rehabilitation Act of 1973, 29 USC 794 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.

All Michigan Medicaid program participants and providers are to ensure compliance with all relevant Federal and State nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the Michigan Medicaid program.

To report noncompliance, contact the Michigan Department of Civil Rights or the U.S. Office for Civil Rights, Department of Health and Human Services. (Refer to the Directory Appendix for contact information.)

SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

MDHHS must terminate or deny a provider's enrollment in Michigan's Medicaid program for the following reasons:

- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.
- Convicted of a relevant crime described under 42 USC 1320a-7(a):
  - Conviction of program-related crimes

    Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program.
  - Conviction relating to patient abuse

    Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.
  - Felony conviction relating to health care fraud

    Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph [1]) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.
  - Felony conviction relating to controlled substance

    Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

  Providers who have been excluded due to one of the federal mandatory exclusions listed above will remain on the MDHHS Sanctioned Provider List until the minimum period for their exclusion has been completed and the provider has requested a lifting of their sanction from the sanctioning body.

- Failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to, the provider's:
  - failure to submit timely and accurate information;
  - failure to cooperate with MDHHS screening methods;
  - failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
  - failure to permit access to provider locations for site visits;
  - falsification of information provided on the enrollment application or subsequent information requests;
  - inability to verify their identity; or
  - failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.
- The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
- The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.
- The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to:
  - murder, rape, abuse or neglect, assault, or other similar crimes against persons;
  - extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes;
  - the use of firearms or dangerous weapons;
  - a felony conviction of theft; or
  - any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
  - any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
  - rape, abuse or neglect, assault, or other similar crimes against persons;
  - extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes;
  - a misdemeanor conviction of theft; or
  - any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

For the purposes of the excluded offenses mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
- there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or
- a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

The criminal history screening will be conducted by MDHHS through reputable and reliable data sources. Screenings for providers will be done as required by law and as deemed necessary by MDHHS for the protection of the Medicaid program and beneficiaries. For criminal offenses that fall under the mandatory exclusions of 42 USC 1320a-7(a), the definition of conviction will conform with 42 USC 1320a-7(i), which may include, but is not limited to, a record relating to criminal conduct that has been expunged.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- may violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.
- may violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

Pursuant to MCL 400.111e, the Medicaid Director may terminate or deny enrollment if that action is necessary to protect the health of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Additionally, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program.

Providers who are already enrolled at the time of a finding by MDHHS will have their enrollment ended as of the date MDHHS was notified of the excluded offense. Claims with dates of service on and after the provider's enrollment termination date will be denied.

NOTE: Individual Home Help providers denied enrollment due to certain program exclusions may still provide services through the Personal Choice and Acknowledgement of Provider Selection process. (Refer to the Providers [Prohibited Providers] Section of the Home Help chapter for more information.)

6.2 Enrollment and Reinstatement After Termination or Denial

Providers who are excluded from participation in the Medicaid program due to a conviction for an excludable crime may request a policy exception upon a showing that an exception is in the best interest of the Medicaid program and of Medicaid beneficiaries. The Medicaid Director has sole discretion under MCL 400.111e(7) to grant a policy exception to lift a sanction from an excluded provider. A request for a policy exception is not a request to participate in Medicaid. Factors that may be considered when determining the approval or denial of a policy exception include, but are not limited to:

- whether the exclusion poses an undue hardship to beneficiaries;
- whether the provider is the sole community physician or sole source of specialized services in the community;
- subsequent offenses of the provider;
- amount of time that has lapsed since the excluded offense;
- whether all conditions, terms of probation or parole, penalties, fines, etc. of the felony or misdemeanor offenses that resulted in exclusion have been fully completed;
- provider's participation in Medicare or other state Medicaid programs; or
- other factors that demonstrate the provider does not otherwise pose a risk to the Medicaid program or beneficiaries.

For providers indefinitely excluded due to a conviction listed in 42 USC 1320a-7(a), or who have been debarred or excluded for any reason by a federal or another state agency, an exception request will not be considered unless the federal or state agency has terminated the exclusion or lifted the sanction. However, reinstatement by, or termination of the exclusion by, a federal or state agency is never the sole determinative factor for policy exceptions under this subsection. For all other exclusions, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program.

Requests for reinstatement must be sent in writing to the Medicaid Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

If a provider requests a policy exception and it is denied, subsequent requests for an exception will only be considered upon providing documentation that a substantive change in circumstances has occurred since the last exception request. Providers may not request a policy exception for an exclusion while a termination or denial of enrollment is still under administrative or judicial appeal. The denial of a policy exception request is not an adverse action and providers may not appeal the denial.

Providers who have been excluded due to one of the convictions listed in 42 USC 1320a-7(a) shall remain on the MDHHS Sanctioned Provider List indefinitely. A policy exception may be requested as described in this section.

MDHHS will address requests for a policy exception within 60 days after all requested information has been provided.

6.3 Suspension

Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS).

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:

- An evaluation of billing practices.
- The prior authorization (PA) process.

- An on-site review of financial and medical records and a written report of this review is filed.
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- A peer review of services or practices.
- A hearing or conference between MDHHS and the provider (and counsel, if so requested).
- Indictment or bindover on charges under the Medicaid or Health Care False Claims Act or similar state/federal statute.

6.4 Loss of Licensure/Limited Licenses

Providers are required to comply with all licensing laws and regulations applicable to the provider's practice or business in Michigan. For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from Medicaid effective the date of final lapse of the provider's license.

Limited or suspended licenses may result in disenrollment or denial of enrollment if MDHHS determines the basis of the action to be detrimental to the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Enrollment will be denied or terminated based on a disciplinary limited or suspended license as designated by the licensing entity. Other non-disciplinary limited licenses recognized for enrollment continue to be accepted.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDHHS does not reimburse for services ordered, prescribed, referred or rendered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

A provider may submit an on-line application to MDHHS to request re-enrollment as a Medicaid provider when their license is reinstated. Refer to the Provider Enrollment Section of this Chapter for information on the enrollment process.

6.5 Payment Suspension

MDHHS may temporarily suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. An allegation of fraud may be from any source, including fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Providers will be notified within 90 days of initiation of payment suspension. The notification will include the general allegations as to the nature of the suspension action, the period of suspension, and the circumstances under which the suspension will be terminated. Providers may submit written evidence for consideration

through the administrative appeal process. All payment suspensions will include referral to the MDHHS Office of Inspector General.

6.6 Appeals

Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. Refer to the Provider Appeal Process section of this chapter for additional information.

SECTION 7 – SANCTIONED, BORDERLAND, AND OUT-OF-STATE/BEYOND BORDERLAND PROVIDERS

7.1 SANCTIONED PROVIDERS

Pursuant to Section 1128 and Section 1902(a)(39) of the Social Security Act, Medicaid does not reimburse providers for any services/items that were ordered, prescribed, referred or rendered by sanctioned (suspended, terminated, or excluded) providers. If a provider is presented with an order, prescription or referral from a sanctioned provider, that provider should inform the beneficiary that the service/item cannot be provided because the provider has been excluded from Medicaid participation. The beneficiary may elect to purchase the service/item after being notified of the provider's sanction and agrees, in writing, to pay for the service/item out of pocket.

Provider sanctions may be initiated by MDHHS, the U.S. Department of Health & Human Services (HHS) (i.e., Medicare), or other sanctioning body. Notice of a provider's sanction is provided in a cumulative list of sanctioned providers and is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

It is recommended providers check the MDHHS Sanctioned Provider List on the MDHHS website, as well as the websites of other sanctioning bodies, to avoid accepting orders, prescriptions or referrals for Medicaid beneficiaries from these sanctioned providers.

Although MDHHS makes every attempt to publish timely, accurate information about sanctioned providers, a sanctioned provider is excluded from Medicaid participation even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a sanctioned provider or a provider acting on an order, prescription or referral from a sanctioned provider must be refunded to Medicaid.

7.2 BORDERLAND PROVIDERS

Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:

Indiana	Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)
Minnesota	Duluth (city)
Ohio	Fulton, Lucas, and Williams (counties)
Wisconsin	Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)

Note for Hospice Providers: An out-of-state/borderland hospice provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless:

- The agency is licensed and Medicare-certified as a hospice in Michigan; or
- The state in which the provider is licensed and certified has a reciprocal licensing agreement with the State of Michigan.

If one of these conditions is met and the hospice provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.

Medicaid will not cover services for a beneficiary who enters a hospice-owned residence outside of Michigan. The Community Health Automated Medicaid Processing System (CHAMPS) will not recognize the core-based statistical area (CBSA) code of another state. Additionally, when a Michigan Medicaid beneficiary voluntarily enters a hospice-owned residence in another state to receive routine hospice care, they are no longer considered a Michigan resident and, therefore, are not eligible for hospice benefits under Michigan Medicaid.

Note for Home Health Providers: An out-of-state/borderland home health provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless they are Medicare certified as a home health agency in Michigan. If this condition is met, and the home health agency provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.

Note for Nursing Facilities: An out-of-state/borderland nursing facility is not allowed to enroll with Michigan Medicaid. Historically, the only borderland nursing facilities that were allowed to enroll with Michigan Medicaid were those facilities where Michigan beneficiaries were admitted to the facilities prior to October 1, 2007 or were admitted where placement was approved by Medicaid due to closure of a Michigan facility. The last of such placements and Medicaid facility enrollment ended August 1, 2016.

7.3 Out of State/Beyond Borderland Providers

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDHHS reimburses out of state providers who are beyond the borderland area if the service meets one of the following criteria:

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the federal Balanced Budget Act of 1997 and its regulations; or
- Medicare and/or private insurance has paid a portion of the service and the provider is billing MDHHS for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDHHS. MDHHS will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.
- Genetic or Molecular laboratory services. Services are subject to clinical PA requirements that would apply if the laboratory provider were located in-state. (Refer to the Laboratory chapter for more information.)

Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services. Providers participating in Medicaid Health Plan and Dental Health Plan networks should refer to the

Dental chapter (Healthy Kids Dental section) and the Medicaid Health Plans chapter of this manual for additional prior authorization information.

Providers must be licensed and/or certified by the appropriate standard-setting authority.

All providers rendering services to Michigan Medicaid beneficiaries must complete the on-line application process described in the Provider Enrollment Section of this Chapter in order to receive reimbursement. Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process.

Out of state/beyond borderland providers enrolled with the Michigan Medicaid program may submit their claims directly to CHAMPS. Providers should refer to the appropriate Billing and Reimbursement chapter of this manual for billing instructions.

MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States.

Out of state/beyond borderland providers have a responsibility to follow Michigan Medicaid policies, including obtaining PA for those services that require PA.

All non-emergency services rendered by providers, except genetic or molecular laboratory services, require the referring provider to obtain written PA from MDHHS as indicated in the Prior Authorization Section of this chapter.

When a Michigan provider has referred a Medicaid beneficiary to a provider beyond the borderland area, the referring provider should instruct the provider to refer to this manual or the MDHHS website for enrollment instructions. (Refer to the Directory Appendix for website information.)

SECTION 8 - DELIVERY OF SERVICES

8.1 FREE CHOICE

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services unless they are patients in a state-owned and-operated psychiatric facility, enrolled in a Medicaid Health Plan (MHP), or otherwise specified.

8.2 RENDERING SERVICES

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their **mihealth** card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the Billing Beneficiaries Section of this chapter for more information.)

8.3 NONCOVERED SERVICES

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- Experimental/investigational drugs, biological agents, procedures, devices or equipment
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use their patient-pay funds to purchase noncovered services subject to MDHHS verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for additional information.)

8.4 Nondiscrimination in Delivery of Service

Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers must take the necessary steps to ensure compliance with all relevant nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the program. Refer to the Nondiscrimination section of this chapter for additional information.

8.5 Service Acceptability

MDHHS may determine that a provider did not order, prescribe, refer, or render services/items within the scope of currently accepted medical/dental practice or the service was not provided within Medicaid limitations. In such cases, MDHHS reviews the situation and may:

- Refuse to reimburse for the service.
- Require the provider to repeat or correct the service at no additional charge to Medicaid or the beneficiary (e.g., an inaccurate vision prescription was written).
- Recover any monies paid to the provider for the service.
- Require the service to be done immediately (e.g., provide services to complete an incomplete examination or treatment).

Failure to comply with any of the last three items may result in the provider's disenrollment from Medicaid.

8.6 Ordering, Prescribing and Referring Services/Items

All providers ordering, prescribing and/or referring services/items to Michigan Medicaid beneficiaries must be enrolled in the Michigan Medicaid program. These regulations apply to Fee for Service Medicaid and Medicaid Health Plan providers. Claims for beneficiaries with Medicare or private insurance coverage will not be exempt from this requirement. (Refer to the specific Billing & Reimbursement chapters for additional information.)

SECTION 9 - PRIOR AUTHORIZATION

9.1 GENERAL INFORMATION

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDHHS requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)

Requests for PA (except pharmacy) may be submitted in writing, via Direct Data Entry (DDE) through CHAMPS, or electronically (utilizing the ASC X12N 278 5010 Health Care Services Review/Request transaction) if the provider is an MDHHS-approved EDI submitter. Providers wishing to submit a 278 transaction should refer to the Electronic Submission Manual and the MDHHS Companion Guide for the HIPAA 278 Health Care Services Review/Request transaction for further information. Both documents are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Refer to the Pharmacy Chapter for information related to pharmacy PA.

PA requirements for MHP enrollees may differ from those described in this manual. Providers should contact the individual plans regarding their authorization requirements.

PA may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits Chapter for additional information.)

9.1.A. FFS DIRECT DATA ENTRY (DDE) IN CHAMPS

The CHAMPS PA system allows FFS providers to submit single PA requests through the online web portal. CHAMPS validates both beneficiary and provider information. An error message is returned to the user if the information is incorrect. Any provider may request PA, however, the provider NPI entered in the servicing provider field must represent the provider who will be rendering the service.

Once the PA request is successfully entered, the provider receives a tracking number. If the request is approved by MDHHS, this tracking number becomes the prior authorization number to use for billing purposes. The tracking number is not valid for claims unless a PA request is approved. Modifications to existing prior authorizations on file can be requested via fax to the Program Review Division. Private Duty Nursing providers with an authorization on file for a beneficiary in the Children's Waiver Program or Habilitation Supports Waiver should contact the Community Mental Health Services Program (CMHSP) for assistance. (Refer to the Directory Appendix for contact information.)

Supporting documentation may be linked to a DDE PA request either through facsimile or electronically. For electronically-submitted documentation, the DDE screen will open Internet Explorer on the user's computer and allow the retrieval of the appropriate record to link to the PA request. The system limits each PA request to 10 document attachments; each attachment is limited to a maximum size of 100MB. For documents submitted via facsimile, CHAMPS generates a cover sheet pre-populated with the beneficiary's ID number and the tracking number of the request. The fax cover sheet

contains the applicable fax number and must precede the documents being uploaded into CHAMPS. There is no system limit for the maximum number of pages for faxed documents.

PA Inquiry allows providers to check on the status of submitted PA requests or query on completed PAs on file. Up to seven (7) years of PA history is accessible to providers in CHAMPS.

9.2 Processing Requests

Based on documentation submitted, the PA request is either approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter. A separate letter is generated for each PA request regardless of the mode of submission and is viewable by providers in CHAMPS. Providers must immediately notify the beneficiary of the approval or denial of the PA request.

Approval of a PA request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

9.2.A. Verbal Prior Authorization

If a service requires PA but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request PA by calling the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)

If the service is required at a time when MDHHS cannot be contacted, the provider may perform the service and call MDHHS by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written PA request (with supporting documentation) to MDHHS within 30 days. If the supporting documentation matches the information relayed for verbal authorization, MDHHS sends an approval to the provider.

9.2.B. Approval

Payment is made only for services provided during the period of time the PA is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The prior authorized service must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Program Review Division should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized, and that service also requires PA which was not obtained or is not covered by Medicaid, the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

9.2.C. Denial

If PA for the service is denied, it must not be billed to Medicaid. The beneficiary will be sent a letter notifying them of the denial with an explanation of their appeal rights. Once notified of the denial, the beneficiary may still wish to receive the service. The provider must reiterate to the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

9.2.D. Reimbursement

Procedure codes that do not have an MDHHS established fee screen require manual pricing. For certain services, manual pricing is completed through the claims processing process which requires documentation to be submitted with the claim. Other types of services require manual pricing to be completed through the PA process. For PA, it is the provider's responsibility to document the acquisition cost for the service or item submitted for consideration. Medicaid does not accept merchandise price quotes, estimates, retail prices, any document or price that does not indicate the actual cost of the item to the provider, or documentation that is greater than 90 days old. MDHHS reserves the right to set a dollar limit on how much MDHHS will reimburse for a Not Otherwise Classified (NOC) code or any manually priced procedure code for a specific range of products.

Documentation that may be accepted for PA requests includes:

- An invoice indicating what the medical supplier actually paid for the item to be provided to the specified beneficiary.
- An invoice indicating what the medical supplier actually paid for the same item requested on the PA but was purchased for a different beneficiary.
- An order form receipt from the manufacturer that indicates what the medical supplier actually paid for the item ordered for the specified beneficiary.
- For the manufacturer and/or custom-fabricated items, cost for materials and number of hours of labor.

Medicaid does not provide reimbursement if:

- The beneficiary was not eligible for Medicaid on the DOS. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For custom-fabricated equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- A service that is prior authorized and rendered in conjunction with another service that requires PA, and PA for the second service was not obtained.
- PA was required but was not obtained.

- The beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- It was determined that PA was requested or obtained after the service was rendered. (The provider should refer to the Verbal Prior Authorization subsection above for an exception to this situation.)
- The service/item was ordered, prescribed or referred by a provider who has been sanctioned, and the sanction was in effect before PA was granted.
- The service/item was ordered, prescribed, or referred by a non-enrolled provider.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, they cannot apply their fee for that service in calculating other reimbursement due to them from Medicaid.

9.3 Prior Authorization (Medicaid Health Plans Only)

Medicaid Health Plans (MHPs) are responsible for authorizing Medicaid-covered services in the Comprehensive Health Care Program (CHCP) benefit package for enrolled Medicaid beneficiaries, with certain exceptions such as emergency services. Providers must contact the MHPs before rendering services to MHP enrollees to obtain PA. Each MHP is responsible for establishing procedures for PA.

9.4 Clinical Trials

PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests, when required, must contain the clinical trial number, be complete, and include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) Submit requests electronically via FFS Direct Data Entry (DDE) in CHAMPS to allow for expedited review. Refer to the Practitioner Chapter for additional information for coverage of routine patient costs for services associated with participation in a qualified clinical trial.

9.5 Custom-Fabricated Medical Equipment, Devices and Medical Supplies

Medicaid is responsible for payment of custom-fabricated equipment or devices, hearing aids, eyeglasses, dentures, prosthetics and orthotics authorized and ordered before the last date of Medicaid eligibility and delivered within 30 days after loss of eligibility. Medicaid or the MHP that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the beneficiary loses eligibility or has an enrollment change (fee-for-service [FFS] to MHP, MHP to FFS or MHP to MHP). The order must be placed before the change in enrollment status, and the service should be delivered within 30 days after the change in enrollment status.

If a provider determines that a beneficiary needs a durable medical equipment (DME) item that is authorized by either MDHHS or the current MHP and is ordered before a change in enrollment status, the party that authorized the service is responsible for payment.

If a custom-fabricated item, medical device, or equipment (e.g., prosthetic limb, custom-fabricated medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary

during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

This policy does not apply to mass-produced, readily available items that can be used by a person other than for whom it was ordered. It also excludes all rental items, all expendable/disposable medical supply items (e.g., diapers, dressings, ostomy supplies, IV infusion supplies) or any item that does not require a length of time (days or weeks) to special order for a specific person.

SECTION 10 - BILLING BENEFICIARIES

10.1 GENERAL INFORMATION

Providers cannot bill beneficiaries for services except in the following situations:

- A Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter for additional information about copayments.)
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS office determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for additional information.)
- For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the MDHHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or their authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability-to-pay amount, even if the patient-pay amount is greater.
- The provider has been notified by MDHHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.
- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that they were liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)
- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).
- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to

advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service.
- Missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider.

If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

If a Medicaid-only beneficiary understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that their **mihealth** card is not accepted and that they are responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.

10.2 Beneficiary Copayment Requirements

Beneficiary copayments may be required for the following Medicaid services:

- Physician office visits (including those provided by physician assistants, advanced practice registered nurses, and podiatrists)
- Chiropractic visits
- Outpatient hospital clinic visits
- Inpatient hospital stays
- Non-emergency use of the emergency room
- Dental services
- Hearing aids
- Pharmacy services
- Vision services

A list of current copayments is available on the MDHHS website. (Refer to the Directory Appendix for website information.) Different copayment requirements may apply for beneficiaries enrolled in a Medicaid Health Plan. Contact the appropriate plan for copayment information.

Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.

10.2.A. Beneficiaries Excluded from Medicaid Copayment Requirements

Copayment requirements apply to Medicaid fee-for-service beneficiaries age 21 and older who do not meet one of the following exceptions:

- Medicare/Medicaid dual eligibles
- Children's Special Health Care Services (CSHCS) beneficiaries (including those also enrolled in Medicaid)
- Inpatient hospital stay initiated by an emergent admission
- Nursing facility residents
- Pregnancy-related services (claim must include a pregnancy-related diagnosis)
- Family planning services (as described in the Family Planning Clinics Chapter of this manual)
- Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plans
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry
- Services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Health Center (THC). Copays for prescriptions filled in an FQHC, RHC, or THC are only exempt based on the beneficiary's eligibility and/or specific drug exclusions listed in the Medicaid Copayments subsection of the Pharmacy Chapter.
- Native American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x)
- Enrollees in the Breast and Cervical Cancer Control Program (BCCCP)

Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. (Refer to the Medicaid Health Plans chapter for additional information.)

10.2.B. Refusal of Service Due to Non-Payment of Copayment

A provider cannot refuse to render care or services to a Medicaid beneficiary if the beneficiary is unable to pay the copayment amount at the time the care or service is provided. However, the uncollected copayment is considered a debt. A provider must accept the beneficiary's assertion that they are unable to pay. No additional proof is required.

Care or services cannot be denied unless the provider has first given the beneficiary:

- Appropriate notice of the debt (including documentation such as a billing statement, invoice, cash register receipt, or other writing showing the copayment amount owed), and
- Reasonable opportunity to pay the debt.

A provider refusing to render care or services based on copayment debt must, at the request of the beneficiary, transfer the beneficiary's treatment record to a provider designated by the beneficiary or, if it is the provider's normal practice, provide the beneficiary a copy of their treatment record, with reasonable promptness under the circumstances. Providers may not charge the beneficiary or MDHHS for providing a copy of treatment records for this purpose.

A provider refusing to render care or services based on copayment debt must refer a fee-for-service beneficiary to the toll-free Medicaid Beneficiary Helpline number on the **mihealth** card if the beneficiary has questions or concerns about the denial or about accessing care or services from another provider. (Refer to the Directory Appendix for Beneficiary Helpline contact information.) Managed care enrollees must be referred to the Health Plan's customer service helpline number contained on the beneficiary's Health Plan card.

For all providers except physicians and dentists (MD, DO, DDS), care or services cannot be denied based on the beneficiary's copayment debt unless the provider:

- Has a written policy regarding denial of service based on copayment debt that includes appropriate notice and a reasonable opportunity for payment. The provider's policy must include the statement that a beneficiary will not be denied an item or service because they cannot pay the copayment for the item or service currently being requested. The policy must include the provider's method of furnishing adequate notice, as well as the minimum length of time and terms of payment allowed by the provider as a reasonable opportunity for payment.
- Has established procedures for maintaining business records that show the amount of the copayment debt, the date when the required notice was provided to the beneficiary, and the date(s) and amount(s) of any payment(s) received on the copayment debt.
- Gives written (or verbal, pursuant to #4 below) notice to the beneficiary at least the greater of 30 days (60 days for hospitals), or the period prescribed by the provider, prior to denial.

  The notice must include:

  - The time period within which the beneficiary must make payment, in whole or at the discretion of the provider in part, on their newly-created copayment debt in order to avoid denial of future service; and
  - The dollar amount of the minimum payment that must be remitted as a prerequisite for continued service; and

- The fact that the beneficiary cannot be denied future care, items, or services if they make the required full or partial payment on their newly-created copayment debt in the above-designated period.

- Gives verbal notice in lieu of written notice when the provider:
  - Publicly and prominently posts their policy regarding denial of service based on copayment debt in a public area such as the provider's reception area; and
  - At the time that verbal notice is given, either provides a copy of the posted policy or verbally informs the beneficiary of the existence and location of the posted notice and the beneficiary's right to a copy of the notice upon request; and
  - Makes a copy of the written policy available to the beneficiary and to MDHHS immediately upon request.

  If a provider gives verbal notice, rather than individual written notice, the provider cannot require the beneficiary to acknowledge in writing that they have been informed of their copayment rights and responsibilities. If the beneficiary refuses to sign an acknowledgement, the provider may note this in their records. Upon receipt of the required payment in the amount and during the time period designated in the individual notice, the provider cannot deny the beneficiary care, items, or services unless and until a new notice meeting the above requirements is given to the beneficiary.

The policies and procedures described above do not affect a provider's right to deny care, items, or services on the basis of debt unrelated to any copayment responsibility, or for other non-financial reasons, consistent with the provider's usual business practices for patients or customers who are not Medicaid beneficiaries.

10.2.C. Cost-Sharing Limits

Medicaid cost-sharing, which includes premiums, contributions, copays and co-insurance incurred by individuals in a Medicaid household, may not exceed an aggregate limit of 5% of family income. MDHHS implements these limits on a calendar quarter basis through the tracking of applicable incurred cost-sharing, including paid claims for services as they are processed through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS). Providers are expected to utilize the cost-sharing information in CHAMPS to determine whether cost-sharing may be assessed at the time of the visit and inform the beneficiary of their cost-sharing obligations.

The eligibility response within CHAMPS includes the following cost-sharing information for the current calendar quarter:

- Cost-Share Met (Y or N);
- Cap Amount Remaining; and
- Copayment (for various services).

If the "Cost-Share Met" is listed as "Y" in CHAMPS, a beneficiary may not be charged any cost-sharing for the remainder of that quarter. In addition, regardless of the approved copayment amount for a particular service, beneficiaries may not be charged any cost-sharing that exceeds the "Cap Amount Remaining" amount listed. Finally, beneficiaries and services that are exempt from cost-sharing as set forth in this Section will remain exempt from cost-sharing.

For pharmacy providers, any remaining copay responsibility will be communicated in the National Council for Prescription Drug Programs (NCPDP) transaction response field 505-F5 (Patient Pay Amount). The Point of Sale (POS) system will determine whether the aggregate limit has been met.

Because CHAMPS tracks beneficiary costs incurred as claims are adjudicated, providers are directed to bill all claims in a timely fashion. Providers are also directed to review the remittance advice to ensure that any copay charged at the time of service was appropriate and to provide refunds if necessary. Medicaid Health Plans that charge copays to Medicaid beneficiaries may also have administrative responsibilities to work with their providers to provide refunds when necessary or as directed by MDHHS.

SECTION 11 - BILLING REQUIREMENTS

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual and in compliance with applicable coding guidelines and conventions.

11.1 BILLING PROVIDER

Providers must not bill MDHHS for services that have not been completed at the time of the billing. For payment, MDHHS requires the provider name and NPI numbers to be reported in any applicable provider loop or field (e.g., attending, billing, ordering, prescribing, referring, rendering, servicing, supervising, etc.) on the claim. It is the responsibility of the attending, ordering, prescribing, referring or supervising provider to share their name, NPI and Michigan Medicaid Program enrollment status with the provider performing the service. Refer to the Billing & Reimbursement Chapters of this manual for additional information and claim completion instructions.

Providers rendering services to residents of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

11.2 CHARGES

Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits Chapter of this manual for additional information.

11.3 TIMELY FILING BILLING LIMITATION

Each claim received by MDHHS receives a unique identifier called a Transaction Control Number (TCN). This is an 18-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the Community Health Automated Medicaid Processing System (CHAMPS). The TCN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for additional information.)

A claim must be initially received and acknowledged (i.e., assigned a TCN) by MDHHS within 12 months from the date of service (DOS).* DOS has several meanings:

- For claims using the institutional format and MHPs, it is the "To" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

*Initial pharmacy claim must be received within 180 days.

All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from DOS.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim (e.g. previous TCNs):

- Claim replacements;
- Claims previously billed under a different provider NPI number;
- Claims previously billed under a different beneficiary ID number; and
- Claims previously billed using a different DOS "statement covers period" for nursing facilities and inpatient hospitals.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant. Note: Nursing Facilities – In cases where a nursing facility may need to submit a claim adjustment due to a change in the beneficiary's patient-pay amount and the claim has not had continuous active review, the adjustment must be submitted within six months from the date MDHHS made the change in the patient-pay amount. The Remarks section must note a reason for the adjustment.

Exceptions may be made to the timely filing billing limitation policy in the following circumstances.

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from MDHHS staff;
  - MDHHS staff failed to enter (or entered erroneous) authorization or restriction in the system;
  - The MDHHS contractor issued an erroneous PA; and
  - Other administrative errors by MDHHS or its contractors that can be documented.

  Retroactive provider enrollment is not considered an exception to the timely filing billing limitation.
- Medicaid beneficiary eligibility/authorization was established retroactively more than 12 months after the DOS.
- Medicaid beneficiary eligibility/authorization was established retroactively less than 12 months after the DOS. Claims will be accepted up to six months after the retroactive eligibility determination date. Providers with claims that meet this retroactive eligibility exception must indicate 'timely filing' in the comment section of the claim.
- Judicial Action/Mandate: A court or MOAHR administrative law judge ordered payment of the claim. A copy of the judicial action or court order may be required to support this exception.

- Medicare processing was delayed: The claim must reflect that Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare. (Refer to the Coordination of Benefits Chapter in this manual for further information.)
- Provider returning overpayment: A claim replacement should be submitted with a comment that the provider is returning money. The replacement should be completed to reflect the return of money (e.g., including primary payer's payment or, if returning all the money, zeroing out the money fields).
- Primary insurance taking back payment after timely filing limitation has passed: Must submit a copy of insurance letter or EOB from primary insurance showing date money was taken back from paid claim. The claim must be submitted within 120 days of the primary insurance letter or remit date.

Providers who have claims meeting either of the first two exception criteria must contact their local MDHHS office to initiate the following exception process:

- The MDHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDHHS.
- Providers can determine if an MSA-1038 has been approved/denied by accessing the MSA-1038 status tool or by contacting the MDHHS caseworker. (Refer to the Directory Appendix, Eligibility Verification, for contact and website information.)
- Once informed of the approval, the provider prepares claims related to the exception, indicating "MSA-1038 approval on file" in the comment section.
- The provider submits claims to MDHHS through the normal CHAMPS submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission or go to the MDHHS website for additional CHAMPS-related information. Questions regarding claims submitted under this exception should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact and website information.)

11.4 Provider Returning Overpayments

Medicaid providers performing self audits may discover an overpayment situation and wish to return the Medicaid overpayment to MDHHS. This process should only be used when the provider is unable to claim adjust or it is not practical to claim adjust. Sending in a check will not correct the underlying claim(s) data. Providers must:

- Document why the money is being returned (i.e., provider self audit) and identify provider NPI information, address, dates of service, and specialty area (i.e., durable medical items, pharmacy, physician practice, hospital, etc.) and include a basic information letter.
- Attach an excel spreadsheet document with the Tax ID, billing NPIs, and associated amounts (if multiple IDs exist for the entity) for the MDHHS Accounting Office to apply credit to.
- Make check payable to "State of Michigan" and mail to the MDHHS/Cashier's Unit - Attn: Bureau of Finance-MCU. (Refer to the Directory Appendix for contact information.)

11.5 Professional Corporation

For services involving multiple visits billed with a single procedure code (e.g., surgery and pre- and post-operative care, prenatal care) or initial or new services, the code/service may be billed only once by a professional corporation. Other members of the corporation may not bill separately any procedures related to the service. This policy includes services rendered in a partnership, employer-employee, or contractor relationship.

11.6 Invoice Completion Fee

A fee for completing the Medicaid claim cannot be charged to Medicaid, the beneficiary, or the beneficiary's representative.

11.7 Claim Documentation

In some cases, MDHHS may require specific information with the claim (e.g., indication of medical necessity). Providers should refer to the provider-specific and Billing & Reimbursement Chapters of this manual for the information that may be needed on the claim.

A claim without the requested information may be reviewed:

- Prior to payment. (The claim may be rejected for missing, incorrect or insufficient information.)
- Subsequent to payment. (A post-payment audit/review may indicate that the information was insufficient or missing and a gross adjustment would be initiated to recover the payment.)

11.8 Claim Certification

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typed, or rubber-stamped on a paper claim.

When a provider's warrant is endorsed or deposited, it is certification that the services billed were actually provided. It further certifies that the claims (paper or electronic) paid by the warrant accurately document that the health care services provided were within the limitation of Medicaid (or compliance with a contract). The warrant's certification applies to original claims as well as resubmitted claims and claim adjustments.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant.

Providers are held responsible for any errors, omissions, or resulting liabilities that may arise from any claim for medical services submitted to MDHHS under the provider's name or NPI number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc. do not release the provider of the responsibility for services billed or signed under the provider's NPI number.

Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.

11.9 Billing Agents

A billing agent that submits Medicaid claims via electronic media must be authorized by MDHHS before submitting claims. Once the billing agent has completed the business-to-business (B2B) testing requirements and is authorized by MDHHS, the provider must authorize the billing agent to submit their claims. The authorization for submitting claims via electronic media must be submitted even if the provider is acting as their own billing agent.

11.9.A. Authorization of Billing Agent

The billing agent initiates the authorization process through completion of the MDHHS CHAMPS PE on-line application. Refer to the Provider Enrollment Section of this Chapter and the Trading Partners portion of the MDHHS website for information on the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

11.9.B. Provider Association with a Billing Agent

The process for a provider to authorize a billing agent to submit claims is accomplished through the CHAMPS PE on-line process. The enrolled provider must enter the on-line system and request association with a specific billing agent. Once that transaction is completed, the provider must notify the billing agent that they may begin submitting claims on the provider's behalf.

11.9.C. Communication with Billing Agents

MDHHS communicates changes in coverages, billing requirements, and fees/rates to its enrolled providers. If a provider contracts with a billing agent, it is the provider's responsibility to assure the billing agent is made aware of any changes that may impact submission of the provider's claims. Providers are responsible for the claims submitted by the billing agent, including improper billings, duplicate payments, etc.

SECTION 12 - THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

Medicaid does not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay (medical/surgical/psychiatric) provided in a non-state-owned facility. Benefit Plan IDs of INCAR-ESO, INCAR-MA, INCAR-MA-E and MA-HMP-INC, if provided in the eligibility response, all indicate that the beneficiary resides in a detention facility.

12.1 ESTATE RECOVERY PROGRAM

Pursuant to 42 USC §1396p, the federal government requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries who received benefits from a state Medicaid program. This is referred to as the Estate Recovery Program. Under some circumstances, the state may choose not to seek or may defer recovery from the estate.

Estate recovery applies only to Medicaid beneficiaries who:

- are 55 years of age or older; and
- received long-term care services any time on or after September 30, 2007.

The Estate Recovery Program can only recover from assets flowing through the probate process.

When a provider has a balance in a patient trust account after the death of a beneficiary, any balance in the account should be refunded to the family to open a probate estate with those funds. Once an estate is opened in probate court, MDHHS will file a claim.

SECTION 13 – REIMBURSEMENT

13.1 PAYMENT IN FULL

Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., copayments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs and PIHPs/CMHSPs/CAs for their Medicaid enrollees.

Contractors or nursing facility (including ICF/IID) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDHHS ability-to-pay amount.

13.2 PRE- AND POST-PAYMENT REVIEW/AUDIT

Providers are subject to pre- and post-payment review/audit or an adjustment to the reimbursement rate.

- In pre-payment review, MDHHS may deny reimbursement for a service until it is satisfied the service meets Medicaid guidelines.
- In post-payment review/audit, MDHHS may initiate an adjustment to obtain monies paid for services that do not comply with Medicaid coverage, billing and/or reimbursement policies or that suspends or disenrolls the provider from Medicaid.

13.3 EMERGENCY SERVICES (MHPS ONLY)

Emergency services to the point of stabilization (as required to be provided under the Emergency Medical Treatment and Active Labor Act [EMTALA]), provided to a MHP enrollee inside or outside the MHP's service area, must be reimbursed by the MHP to the provider of services.

13.4 NON-PAYMENT AND REPORTING REQUIREMENTS FOR PROVIDER PREVENTABLE CONDITIONS (PPCS)

In accordance with federal regulations, Michigan Medicaid is prohibited from reimbursing providers for services related to Provider Preventable Conditions (PPCs), as defined below. Providers are required to report the occurrence of PPCs. This policy applies to all services performed on Medicaid beneficiaries, including dual-eligible beneficiaries and those enrolled in Medicaid Health Plans. MDHHS aligns with Medicare's policy and billing guidelines.

13.4.A. CATEGORIES OF PROVIDER PREVENTABLE CONDITIONS

Health Care Acquired Conditions (HCAC)	Applies to inpatient hospital settings and includes, at a minimum, the full list of conditions/secondary diagnosis codes identified by CMS as HCACs when not present on hospital admission.

Other Provider Preventable Conditions (OPPC)	Applies to conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Conditions currently identified by CMS include: ▪ wrong surgical or other invasive procedure performed on a patient; ▪ surgical or other invasive surgery performed on the wrong body part; and ▪ surgical or other invasive procedure performed on the wrong patient.

13.4.B. Payment Adjustment and Reporting Requirements for PPCs

Any reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment. The beneficiary and/or their family are held harmless and the provider and/or facility/hospital must not bill the Medicaid beneficiary or their family (including co-payment, deductibles or coinsurance) for PPCs.

MDHHS will not accept Medicare primary or Medicaid secondary professional or institutional crossover claims resulting in zero liability.

Providers must report the occurrence of a PPC through the appropriate claim(s) type submission process. Providers are referred to the Billing & Reimbursement Chapters of this manual for specific information on reporting requirements and claim submission.

13.5 Factoring

Factoring of Medicaid accounts by any provider is prohibited. A factor is defined in federal regulations as "an organization, that is, a collection agency or service bureau which advances money to a provider for their accounts receivable which have been assigned or sold, or otherwise transferred to this organization for an added fee or a deduction of the accounts receivable." Power of attorney arrangements, under which a check is payable to the provider but can be cashed by a factor, are prohibited. However, payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order.

Factor does not include a business representative, such as a billing agent or an accounting firm, which renders statements and receives payments in the name of the individual provider as long as the business representative's compensation for this service is:

- Reasonably related to the cost of processing the claim;
- Not related, in any way, to the dollar amount to be billed or collected; and
- Not dependent upon the actual collection of payment.

This policy is not applicable to State-owned and -operated facilities.

SECTION 14 – RECORD KEEPING

14.1 RECORD RETENTION

Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records include fiscal and clinical records as discussed below. Appointment books and any logs are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes), and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than seven years from the DOS, regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

14.2 ORDERS, PRESCRIPTIONS AND REFERRALS

Providers arranging or rendering services upon the order, prescription or referral of another provider (e.g., physician) must maintain that order, prescription and/or referral for a period of seven years.

14.3 BENEFICIARY IDENTIFICATION INFORMATION

Providers must retain the following beneficiary identification information in their records:

- Name
- Medicaid ID number
- Medical record number
- Address, including zip code
- Birth date
- Telephone number, if available
- Any private health insurance information for the beneficiary, if available

14.4 AVAILABILITY OF RECORDS

Providers are required to permit MDHHS personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary because the purpose for the disclosure is permitted under the HIPAA Privacy rule. Health plans contracting with the MDHHS must be permitted access to all information relating to services reimbursed by the health plan.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained. (Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid.) Records may only be released to other individuals if they

have a release signed by the beneficiary authorizing access to their records or if the disclosure is for a permitted purpose under all applicable confidentiality laws.

14.5 Confidentiality

MDHHS complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary and protects this relationship using the minimum amount of information necessary for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or their representative, unless the provider has a signed release from the beneficiary or the disclosure is for a permitted purpose under all applicable confidentiality laws (refer to the Availability of Records subsection of this chapter for additional information). Providers are bound to all HIPAA privacy and security requirements as federally mandated.

If the provider receives a court order, a subpoena, beneficiary request, or other authorized request for medical bills, payment, or claims adjudication information, the information should be released. At the same time, copies of the court order, subpoena, beneficiary request, other authorized request, and any additional information should be faxed to the MDHHS TPL Section. (Refer to the Directory Appendix for contact information.)

If there is a reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, the provider should contact the TPL Section. TPL will make the necessary arrangements to collect the duplicate payment from the third-party source.

If the provider questions the appropriateness of releasing beneficiary records, they are encouraged to seek legal counsel before doing so.

14.5.A. Standard Consent Form

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

14.6 Fiscal Records

The following fiscal records must be maintained:

- Copies of Remittance Advices (RA);
- PA requests and approvals for services and supplies (including managed care authorizations);
- Verification of medical necessity and the provider's usual and customary charge for the noncovered service;
- Record of third-party payments; and
- Copies of purchase invoices for items offered or supplied to the beneficiary.

14.7 Clinical Records

The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy in this manual for additional documentation requirements. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering health care professional.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted health care terminology. Symbols, marks, etc. unique to that provider must not be used.

Examples:

- When a test is performed, at a minimum, the test value for that beneficiary for that test must be noted. Additionally, the normal range of values for the testing methodology should be annotated in the record.
- When an x-ray is taken, the results or findings must be indicated. For example, a chest x-ray may indicate "no pulmonary edema present" or "no consolidation."
- When a physical examination is performed, pertinent results or readings must appear.
- If blood pressure is taken, the actual reading must appear.
- If heart, lungs, eyes, etc. are checked, the results or findings must be detailed.
- Medical/surgical procedures performed must be sufficiently documented to allow another professional to reconstruct what transpired (e.g., "I-D" is not sufficient documentation).

- When a complete physical exam is rendered, the level of service must be fully documented.
- If private duty nursing is provided, the care provided during each hour must be fully detailed.

Hospitals must retain any clinical information required to comply with 42 CFR 482.24. A nursing facility must retain any clinical information required to comply with 42 CFR 483.75 and the plan of care must comply with 42 CFR 483.20(d). These regulations are available from MDHHS or Centers for Medicare & Medicaid Services (CMS). (Hospitals and nursing facilities should refer to the Reimbursement Appendix of their chapters in this manual for additional record keeping requirements.)

Clinical Documentation Requirements

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Nursing Facility/Therapies	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Services Program	Vision
Date of Each Visit	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖		✖	✖	✖	✖	✖
Begin Time & End Time if Service is Time-Specific According to Procedure/Revenue Code Billed	✖	✖	✖			✖	✖	✖	✖	✖		✖	✖	✖		✖	✖	✖	
Presenting Symptom, Condition	✖	✖	✖	✖	✖	✖	✖	✖	✖				✖			✖	✖	✖	
Diagnosis	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖		✖	✖	✖	✖	✖
Patient Histories, Plans of Care, Progress Notes, Consultation Reports	✖	✖	✖	✖		✖	✖	✖	✖		✖	✖	✖			✖	✖	✖	
Result of Exams		✖	✖	✖		✖	✖	✖	✖							✖	✖	✖	
Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are Ordered, Prescribed, Referred, or Rendered	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖	✖			✖	✖	✖	✖	
Physical Assessments and/or nursing activities that pertain to care provided & support the services rendered and billed	✖	✖	✖	✖			✖	✖	✖			✖	✖			✖	✖	✖	
Orders for Tests & Test Results		✖	✖	✖	✖	✖	✖	✖	✖	✖					✖	✖	✖	✖	
Pictorial Records or Graphs & Written Interpretations of Tests	✖	✖	✖	✖		✖			✖	✖						✖		✖	
Identification of Specimen, Type & Source				✖			✖		✖	✖						✖	✖		
Test Methodology		✖	✖	✖					✖	✖						✖			

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Nursing Facility/Therapies	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Services Program	Vision
Name, Strength, Dosage, Quantity & Route of Drug, and Time Administered	✖	✖	✖	✖			✖	✖	✖						✖	✖	✖	✖	
Ambulance Requestor's Name, Origination/ Terminating Location, Level & Type of Service	✖								✖							✖		✖	
Ordering, Prescribing or Referring Physician		✖	✖	✖		✖	✖	✖	✖	✖	✖	✖	✖		✖	✖	✖	✖	✖
Transportation Information other than Ambulance		✖							✖				✖					✖	
Other documentation necessary to process request							✖	✖			✖		✖				✖	✖	✖

* Includes MD, DO, DPM, DC, OD, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physician Assistant, Advanced Practice Registered Nurse, Physical Therapist, Oral-Maxillofacial Surgeon, Medical Clinics (e.g., FQHCs, Public Health Clinics).

SECTION 15 – POST-PAYMENT REVIEW AND FRAUD/ABUSE

All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that all services/items, providers, and settings were appropriate, necessary, and comply with Medicaid policy. Post-payment review also verifies that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.), and that third party resources were utilized to the fullest extent available.

15.1 MDHHS OFFICE OF INSPECTOR GENERAL

The MDHHS Office of Inspector General, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDHHS, contact the Office of Inspector General. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Office of Inspector General to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

15.2 STATE LAW

The Michigan Department of Attorney General uses the following State laws for investigating provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 et. seq.) An individual, whether a provider, an employee, or an accomplice, convicted of such an activity is subject to a fine of up to $50,000 and a prison sentence of four to ten years for each count, as well as full restitution to Medicaid of all funds fraudulently obtained. The provider may be suspended from participating in Medicaid for a period of time and, in some instances, their license to practice their profession may be suspended or revoked.

  Examples of Medicaid fraud are:

  - Billing for Services Not Rendered: A provider bills Medicaid for a treatment or procedure that was not actually performed (e.g., laboratory tests or x-rays that were not taken, full dentures were prior authorized and billed for when a partial denture was actually supplied).
  - Billing Without Reporting Other Resources: A provider bills Medicaid the full charge for a service without reporting the amount billed and received from another source (e.g., a private insurance company) or charging the patient for the service or a copay for a covered benefit.
  - Billing for a Brand Name Drug Not Dispensed: A pharmacy bills Medicaid for a brand name drug when a generic substitute (at a lower cost) was actually dispensed to the beneficiary.
  - Billing for Unnecessary Services: A provider misrepresents the diagnosis and symptoms on a beneficiary's record in order to provide and bill for unnecessary tests and procedures.

- Billing a DOS Other Than the Actual Date the Service was Rendered: A provider indicates a DOS other than the actual DOS that was during a time of beneficiary ineligibility or service noncoverage.
- Receiving Kickbacks: An ancillary provider (e.g., physical therapist, laboratory, pharmacy) may agree to pay a physician, nursing facility, or hospital administrator or owner a portion of their Medicaid reimbursement for services rendered to the physician's patient or a beneficiary residing in the facility. Payments to a physician or facility administrator or owner may be a cash payment, a vacation trip, a leased vehicle, inflated rental for space, etc. Often a kickback arrangement results in unnecessary tests or services being provided to the beneficiary in order to generate additional reimbursement.
- Fraudulent Cost Reports: A nursing facility or hospital including nonallowable costs or false information (e.g., understate patient census days) or including nonpatient care expenses (e.g., landscaping, interior design, or remodeling at the administrator's or owner's personal residence) in its cost report to justify a higher per diem or reimbursement rate from Medicaid.

- Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from Medicaid.
- Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from Medicaid or the denial, suspension, or revocation of a provider's license.

MDHHS encourages provider assistance in reducing and reporting provider fraud and abuse in Medicaid and violation of HIPAA Privacy regulations. Any provider or employee suspecting that a fraudulent activity is occurring should contact the Michigan Department of Attorney General. (Refer to the Directory Appendix for contact information.)

15.3 Federal Law

The Office of Inspector General of the U.S. Department of Health & Human Services (HHS) investigates provider fraud, abuse and violation of HIPAA Privacy and Security regulations under federal laws.

The following federal laws are primarily used:

- Social Security Act (Section 1909). A conviction resulting in a penalty of up to five years imprisonment and/or a $10,000 fine.
- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than $2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.

To report fraudulent activities to the federal investigators, contact the Office of Inspector General of the U.S. Department of Health & Human Services (HHS). Complaints regarding Michigan health facilities may be reported to the Michigan Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

15.4 Patient Abuse

Under federal law, the Department of Attorney General, Health Care Fraud Division (Medicaid Fraud Control Unit) is mandated to investigate and prosecute instances of patient abuse occurring in any Michigan facility receiving Medicaid funds.

Examples of patient abuse are:

- Physical abuse, involving assaulting, striking, or sexually abusing a patient.
- Threat or perceived threat of physical or sexual abuse.
- Neglect resulting from inadequate medical or custodial care or other situations that create health risks to the patient.
- Financial abuse, including misappropriation of patient's personal funds, comingling of patient and facility funds.
- Use of patient funds to pay for facility operations.
- Theft of patient's property.

The above examples are not all inclusive.

Complaints involving suspected abuse of patients within any Michigan facility receiving Medicaid funds should be reported to the Michigan Department of Attorney General's 24-hour toll-free hotline. Complaints may also be mailed to the Attorney General's Medicaid Fraud Unit. (Refer to the Directory Appendix for contact information.)

Pursuant to Section 111b of the Social Welfare Act of 1939 (PA 280, as amended, MCLA 400.111b[7]), a provider is required to make available, to authorized agents of the Department of Attorney General, any record required that must be maintained as a condition of participation in Medicaid.

The Michigan Department of Attorney General is also empowered to investigate and prosecute any complaint involving patient abuse by a provider that receives Medicaid funds. It does not matter whether or not the abused patient is receiving Medicaid benefits. (Patient abuse is defined as harm or threat of harm to a patient's health or welfare by a person responsible for the patient's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, or maltreatment.)

15.5 Beneficiary Fraud/Abuse

A provider can contact the local MDHHS office in the beneficiary's county of residence to report beneficiary fraud, or contact the Office of Inspector General's Recipient Fraud Unit Hotline. (Refer to the Directory Appendix for contact information.)

The provider can also report beneficiary over-utilization of services by contacting the local MDHHS worker or the Benefits Monitoring Program. (Refer to the Directory Appendix for contact information.)

SECTION 16 - PROVIDER APPEAL PROCESS

Any provider participating in, or applicant wishing to participate in, Medicaid has the right to appeal any adverse action taken by MDHHS unless the adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation, court's findings in a criminal case). The method of appeal depends upon the provider type and is subject to the Social Welfare Act, Public Act 280 of 1939 (MCL 400.01 et seq.); Chapters 4 and 6 of the Administrative Procedures Act of 1969 (MCL 24.271 to 24.287, MCL 24.301 to 24.306); and the Public Health Code, Public Act 368 of 1978 (MCL 333.20173b). Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective chapters of this manual for the appropriate steps and time frames for appeal.

Any questions regarding this appeal process should be directed to MOAHR. (Refer to the Directory Appendix for contact information.)

SECTION 17 - REVIEW OF PROPOSED CHANGES

The following guidelines for the development of policies, procedures, forms, and instructions apply to the Medicaid, Children's Special Health Care Services, and other health insurance programs administered by MDHHS.

MDHHS consults with affected providers and other interested parties on those proposed changes in Medicaid policies, procedures, forms, and instructions which are determined significant enough to be communicated to providers by means of a provider bulletin. This consultation process involves a notification of the proposed change and the reasons for the change. MDHHS includes the distribution of draft policy to those parties who have expressed interest in reviewing and commenting on the changes.

Affected provider means any enrolled provider or provider association/organization that is impacted by the proposed changes. Any affected provider or other interested party who would like an opportunity to comment on any proposed changes in their area of interest (e.g., podiatry, hospital, vision) may do so.

Visit the MDHHS website to review draft policies or to request draft policies be sent to you for comment. You may also contact MDHHS directly to request to participate in the policy promulgation process. (Refer to the Directory Appendix for contact information.)

Your request to receive draft policies must include:

- Provider's/Individual's name;
- Telephone number;
- E-mail address;
- Involvement with Medicaid (e.g., Medicaid provider, drug manufacturer, interested party);
- Association/organization represented (if applicable); and
- Specific area(s) of interest to review and comment on (e.g., physician, ambulance, hospital, Maternal Infant Health Program (MIHP), dental, nursing facilities).

Copies of draft bulletins are sent to interested parties via e-mail and are posted on the MDHHS website for a minimum of 30 days. Anyone wishing to comment on proposed changes may submit comments electronically, by fax or by US mail within the comment period.

Comments received are considered and suggestions may be incorporated in the final policy if determined appropriate. Upon completion of the consultation process, a provider bulletin serves as final notice of the change. A summary of the comments made, MDHHS response, and a copy of the final bulletin are sent to those who submitted comments. Proposed changes may have to be implemented before comments are considered if specific action is ordered by governmental entities having authority over MDHHS with time frames that do not allow full compliance with the consultation process. In these cases, comments are requested from affected providers and are considered for incorporation after the implementation of the change.

MDHHS consults with the Medical Care Advisory Council (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. Numerous provider associations and organizations are also involved in the review process. A provider who feels that their association or the Medical Care Advisory Council adequately represents them may not wish to be included on the provider consultation list.

SECTION 18 - ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

The American Recovery and Reinvestment Act of 2009 (Recovery Act) provides the opportunity for state Medicaid programs to improve the nation's healthcare through health information technology (HIT) by authorizing incentives for certain eligible professionals (EP), eligible hospitals (EH), and Critical Access Hospitals (CAH) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use of EHR technology for up to five remaining participation years.

The HIT provisions of the Recovery Act are primarily found in Title XIII, Division A, Health Information Technology, and in Title IV, Division B, Medicare and Medicaid Health Information Technology. These titles, taken together, are referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Michigan Medicaid EHR Incentive Program is consistent with the Centers for Medicare & Medicaid Services (CMS) Final Rule 0033 published in the Federal Register (July 28, 2010).

The Recovery Act established 100 percent Federal Financial Participation (FFP) to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate, including support services, staff training, and certified EHR technology.

Eligible professionals and hospitals must meet patient volume thresholds to be eligible for the program.

Incentive payments after the initial adoption, implementation, and upgrading of EHR technology require the provider to demonstrate "meaningful use" of the EHR technology. This is done through a means determined by the State and approved by CMS. The State may also require providers to report clinical quality measures as a part of "meaningful use". As required by CMS, the EHR technology must be compatible with State and Federal administrative management systems and certified with the Certification of Health IT Program under the Office of the National Coordinator for Health Information Technology (ONC).

To participate in the Medicaid EHR incentive program, providers must:

- register with the National Level Repository (NLR) at the federal level. To register with the NLR, providers must have a National Provider Identifier (NPI).
- register as a provider in the Community Health Automated Medicaid Processing System (CHAMPS). Those who are providing services through managed care entities must be individually registered as a Medicaid provider in CHAMPS to verify the provider is in good-standing and is eligible to receive an EHR incentive. Revisions to provider information in the EHR section of CHAMPS will need to be updated by the provider through the NLR.
- have an active user account in the National Plan and Provider Enumeration System (NPPES).
- Hospitals must be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS).

CMS will use the NLR, NPPES and PECOS to register the provider for the program and verify their registration prior to notifying Michigan of eligibility status.

Information specific to the Hospital EHR Incentive Program can be found in the Hospital Reimbursement Appendix Chapter of the Provider Manual. Additional information can be found on websites specific to the Incentive Program. (Refer to the Directory Appendix for website information.)

BENEFICIARY ELIGIBILITY

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SECTION 1 – DETERMINATION OF ELIGIBILITY

This chapter applies to all providers.

1.1 LOCAL MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE DETERMINATION

Eligibility for Medicaid and most other health programs is determined at the local Michigan Department of Health and Human Services (MDHHS) office. MDHHS reviews the beneficiary's financial and nonfinancial (e.g., disability, age) factors and determines the types of assistance for which the beneficiary is eligible. Once eligibility is established, data from MDHHS is available via the CHAMPS Eligibility Inquiry. CHAMPS will also issue a **mihealth** card for new beneficiaries.

The MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) determines eligibility for Children's Special Health Care Services (CSHCS).

Some Medicaid beneficiaries are in a deductible situation. This means the beneficiary has met all Medicaid eligibility criteria except they have excess income. (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)

Migrant agricultural workers may also be eligible for health care benefits. However, due to the transient nature of the migrant population, they might not receive their **mihealth** card. The provider must verify eligibility using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS. (Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

1.2 ELIGIBILITY BEGIN DATE

Coverage is usually effective the first day of the month that the beneficiary becomes eligible.

- Not all beneficiaries, however, are eligible beginning the first day of the month. Coverage may become effective the actual day the beneficiary becomes eligible.
- In some instances, the beneficiary's eligibility may be retroactive up to three months prior to the month of application. This may occur if, during the retroactive period:
  - All eligibility requirements for the specific health care program were met; and
  - Medical services were rendered.

The provider may submit claims to the Michigan Department of Health and Human Services (MDHHS) for payment of any covered services rendered during the beneficiary's eligibility period. If the beneficiary has previously paid for services and the provider has billed MDHHS for the same services, the provider must refund to the beneficiary the portion of payment the beneficiary is responsible for, regardless of the amount MDHHS pays. (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)

1.3 Redeterminations

Beneficiary eligibility is redetermined annually but may occur more often as case circumstances dictate. Beneficiaries are notified of the need to have their cases redetermined and the process to be followed to accomplish this.

1.4 Beneficiary Appeals

Beneficiaries may appeal their eligibility determination/redetermination by contacting their local MDHHS office.

1.5 Corrective Action

Beneficiaries that have been denied Medicaid eligibility and have filed a hearing request may be entitled to a reimbursement if they paid for Medicaid covered services during a corrective action period. The corrective action period begins on the date the hearing request is received by MDHHS and ends on the date that eligibility is established. The services received must have been provided during the established eligibility period, including any months of established retroactive eligibility.

The provider has the option to reimburse the beneficiary in full and bill Medicaid for services rendered. MDHHS encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider chooses not to reimburse the beneficiary, the beneficiary can request a direct reimbursement from the State.

In order to be eligible for a direct reimbursement from the State, the beneficiary, or someone legally responsible for the beneficiary's bills, must have paid for a Medicaid covered service during the corrective action period. The beneficiary cannot receive reimbursement for any required copays, patient pay amounts, amounts used to meet a Medicaid deductible, or care or services paid for through private insurance, Medicare, or any other form of government-sponsored or private health care coverage.

To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received during the established eligibility period or which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDHHS.

Bills must include or contain:

- Beneficiary name
- Date the care or service was received
- Amount charged for the care or service
- Amount paid by the beneficiary or legally responsible party
- Date the bill was paid
- Procedure code(s) for the care or service
- Description of each care or service, e.g., office visit, physical therapy, etc. The drug name, quantity dispensed, and the name of the prescribing physician must be included for prescriptions.
- Proof of any payment made by a third party, such as an insurance company

SECTION 2 – MIHEALTH CARD

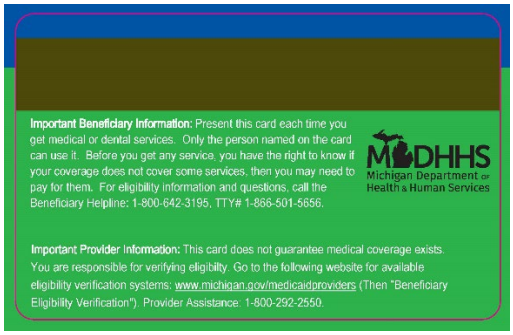
The **mihealth** card is issued for the following programs:

- Medicaid
- Healthy Michigan Plan
- CSHCS
- Maternity Outpatient Medical Services (MOMS)

The provider must verify eligibility using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS.

(Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

The **mihealth** card is a plastic, magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a family is determined eligible for a health program, a **mihealth** card is issued to each eligible person in the household. All cards for a household are mailed to the head of the household. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified using the CHAMPS Eligibility Inquiry that the person is covered. An example of the card follows:



The provider can use the **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry by entering the beneficiary ID number or swiping the card using a magnetic strip reader.

The 10-digit beneficiary identification (ID) number obtained from the CHAMPS Eligibility Inquiry must be used when billing Medicaid.

The provider should request the beneficiary present a **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry to verify health program eligibility before rendering any service. If the beneficiary does not have a **mihealth** card, the provider can also access the beneficiary's eligibility information with the following additional search methods:

- Member ID/Client Identification Number (CIN)/Pending Eligibility Recipient Identification (RID)
- Last Name, First Name and Date of Birth
- Last Name, First Name and Social Security Number (SSN)
- SSN and Date of Birth

Additional search options (use if needed with one of the search options above to obtain a unique member match):

- Gender
- Zip Code
- Case Number

If the beneficiary has lost their **mihealth** card, a replacement card may be issued by contacting the Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) The provider is encouraged to verify a beneficiary's identity by requesting additional identification (e.g., driver's license, State Police ID, Social Security Card).

If the provider suspects fraud, the case should be reported to the MDHHS Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Suspected cases of beneficiary program abuse should be sent to the MDHHS Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Occasionally, the provider may see a Statement of Medical Services Paid (MSA-110-EOB). This statement is for the beneficiary's information only and indicates services received and paid on their behalf by MDHHS.

2.1 Benefit Plans [Changes Made 4/1/2025 & 7/1/2025]

Providers will need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine a beneficiary's program coverage and related covered services for a specific date of service. A **"No Records Found!"** message will be displayed under the Benefit Plans section of the CHAMPS eligibility response if there is no Benefit Plan on file for the DOS entered.

Service type codes designate a covered benefit category at the benefit plan level if applicable. The service type codes at the benefit category level are applied unless a more specific service type code more closely describes the coverage intent of a benefit plan. For a complete listing of all service type codes and descriptions, refer to the CHAMPS information posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
ALMB	Additional Low Income Medicare Beneficiary	This benefit plan is part of the Medicare Savings Program (MSP), also known as the "Buy-In" Program. It pays the Medicare Part B premium.	No Benefits	XIX	N/A
APS	Ambulatory Prenatal Services	This program provides presumptive eligibility for pregnant women limited to ambulatory prenatal care services only. Covered services include physician visits for prenatal care, prescription drugs related to pregnancy, and prenatal laboratory tests.	Fee-for-service	XIX	4, 5, 50, 69, 88, 98, BU
		(text deleted 7/1/2025)			
BHHMP	Medicaid Behavioral Health NOT Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS).	Managed Care Organization	XIX	AL, MH
BHHMP-MHP	Healthy Michigan Plan Behavioral Health Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).	Managed Care Organization	XIX	AI, MH
BHMA	Medicaid Behavioral Health NOT Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS).	Managed Care Organization	XIX	AI, MH

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
BHMA-MHP	Medicaid Behavioral Health Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).	Managed Care Organization	XIX	AI, MH
BIS	Brain Injury Services	Brain Injury Services (BIS) are services and supports provided to persons aged 21 and older with a qualifying brain injury who, but for the provision of these services, would otherwise be served within an institutional setting. The program provides critical rehabilitation and support in the post-acute injury period with the goal of assisting the participant in becoming capable of living in the most independent setting.	Fee for Service	XIX	A9
BMP	Benefits Monitoring Program	The objectives of the Benefits Monitoring Program (BMP) are to promote quality health care, identify beneficiaries that may be mis/over-utilizing Medicaid benefits, modify improper utilization of services through education and monitoring, and ensure that beneficiaries are receiving medically necessary services. Beneficiaries remain in BMP through changes in eligibility, including enrollment into managed care. For beneficiaries with managed care, the Medicaid Health Plan (MHP) coordinates the member's care.	Managed Care Organization	XIX	N/A

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
CCBHC	Certified Community Behavioral Health Clinic	The CCBHC Demonstration benefit plan will reimburse state certified CCBHC sites for providing a comprehensive array of quality behavioral health services. CCBHCs will receive a fixed daily clinic-specific rate (known as a PPS-1 rate) for all CCBHC services provided on a given day, and individuals are eligible for the benefit if they have a mental health or substance use disorder diagnosis, regardless of Medicaid eligibility. CCBHCs are federally required to provide nine core behavioral health services and must meet stringent standards for care coordination, quality and financial reporting, staffing, and governance.	Managed Care Organization	XIX-XXI	AI, MH
CSHCS	Children's Special Health Care Services	This plan is designed to find, diagnose, and treat children and young adults under age 26 with chronic illness or disabling conditions. Persons over age 26 with chronic cystic fibrosis, certain blood coagulation disorders, or hereditary blood cell disorders commonly known as sickle cell disease may also qualify. Covers services related to the client's CSHCS-qualifying diagnoses. Certain providers must be authorized on a client file.	Fee-for-Service	V, GF	1, 35, 47, 48, 50, 71, 86, 88, 98, AL, UC (Most providers must be authorized)
CSHCS-MC	Children's Special Health Care Services – Managed Care	This plan is assigned to CSHCS beneficiaries who also have full Medicaid coverage and are enrolled in a Medicaid Health Plan (MHP). The MHP receives a capitation payment and provides the full range of covered services. Specific services carved out of the MHP contract will remain covered through MA Fee-For-Service.	Managed Care Organization	XIX	1, 35, 47, 48, 50, 71, 86, 88, 98, AL, UC
CSHCS-MH	CSHCS Medical Home	This is a capitated "case management" benefit plan for CSHCS members. CSHCS Medical Home clients are identified by the Medical Home Indicator in the member's CSHCS eligibility file.	Managed Care Organization	V	CQ

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
CTS	Community Transition Services	Community transition services (CTS) are Medicaid funded services provided to qualified individuals who currently reside in a nursing facility, hospital, or other institution and have expressed a desire to return to the community, but who have barriers to a discharge that cannot be met by discharge staff. CTS may also be provided to individuals in the community who previously transitioned and are at risk for going back to the nursing facility or other institution.	Fee for Service	XIX	TC
CWP-MC	Children's Waiver Program Managed Care	This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with developmental disabilities who are enrolled in the Children's Waiver Program (CWP). The CWP is a statewide managed care program. The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who have challenging behaviors and/or complex medical needs, meet the criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) and who are at risk for placement without waiver services.	Managed Care Organization	XIX	N/A

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
DHIP	Foster Care and CPS Incentive Payment	This benefit plan is designed to provide an incentive payment to the PIHPs to serve Medicaid-eligible children in foster care and Medicaid-eligible children in Child Protective Services, Risk Category I and II. There are two incentive payment options: ▪ Incentive Payment 1 – is at least two different non-assessment behavioral health services were provided in the eligible month. ▪ Incentive Payment 2 – is at least one of either home-based services or wraparound services were provided in the eligible month. If a PIHP provides services to a beneficiary in a given month meeting the criteria for both Incentive Payment 1 and 2, the PIHP will only receive payment for Incentive Payment 2.	Managed Care Organization	XIX	MH
HHBH	Health Home Behavioral Health	Medicaid Health Home services are intended for beneficiaries with Severe Mental Illness (SMI) who have experienced high rates of inpatient hospital admissions or high rates of hospital emergency department usage and who may or may not have other chronic physical health conditions that are amenable to care coordination and management by the health home (i.e., congestive heart failure, insulin treated diabetes, chronic obstructive pulmonary disorder, seizure disorder). Individuals to whom these conditions apply may be determined by the state to be eligible to receive Health Home services.	Managed Care Organization	XIX	AI, MH

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
HH MICARE	Health Home MI Care Team	MI Care Team services are intended for Medicaid beneficiaries with specific chronic behavioral and physical health conditions, which includes a diagnosis of depression and/or anxiety and at least one of the following: heart disease, COPD, hypertension, diabetes, or asthma. Individuals to whom these conditions apply may be determined by the State to be eligible to receive MI Care Team services. MI Care Team services include a personalized care management plan and intense care coordination that addresses the physical and social needs of the individual.	Managed Care Organization	XIX	CQ
HHO	Opioid Health Home	Substance Use Disorder Health Home, dba Opioid Health Home (HHO), services are intended for Medicaid beneficiaries with a diagnosis of opioid use disorder, alcohol use disorder, stimulant use disorder in addition to having or being at risk of any other chronic condition. Individuals to whom these conditions apply may be determined by the State to be eligible to receive HHO services. HHO services include a personalized care management plan and intense care coordination that addresses the totality of a beneficiary's physical, social, and recovery-oriented needs.	Managed Care Organization	XIX	AI, CQ **(added 4/1/2025)**
HK - Dental	Healthy Kids Dental	MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHPs are paid a monthly capitation rate to provide covered services to enrolled Medicaid beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services. DHPs may cover additional dental services not included on the MDHHS Dental Fee Schedule. Providers must contact the DHP for specific information about covered HKD benefits.	Managed Care Organization	XIX-XXI	35

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
HK-EXP	Full Fee-for-Service Healthy Kids - Expansion	Benefits mirror Fee-for-Service Medicaid. This benefit plan covers children who are under the age of 19 from 100% FPL up to 160% FPL. This benefit plan is funded by CHIP.	Fee-for-Service	XXI	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan is not assigned for DOS)
HK-EXP-ESO	Healthy Kids - Expansion - Emergency Services Only	Benefits mirror Medical Assistance Emergency Services Only (MA-ESO). Children who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP. [2]	Fee-for-Service	XXI	1, 47, 48, 50, 86, 88, 91, 92, MH, UC Emergency Services Only
Hospice	Hospice	This healthcare program is designed to meet the needs of terminally ill individuals when the individual decides that curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the needs of the individual with a terminal illness, while also considering family needs. Michigan Medicaid covers hospice care for a terminally ill beneficiary whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director.	Fee-for-Service	XIX	45

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
HSW-MC	HSW Habilitation Supports Waiver Program Managed Care	Beneficiaries with intellectual or developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan services.	Managed Care Organization	XIX	N/A
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	The facility primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities, but does not provide the level of care or treatment available in a hospital or SNF. This is an all-inclusive program.	Fee-for-Service	XIX	CG
ICO-MC	Integrated Care - MI Health Link	This capitated managed care program is for beneficiaries who are age 21 or older and who are dually eligible for Medicare and Medicaid. The benefit plan is active only in parts of the state. The benefit includes all Medicare and Medicaid physical health services, long term supports and services, and 1915b/c waiver services for qualifying individuals.	Managed Care Organization	XIX	1, 33, 35, 42, 47, 48, 50, 54, 56, 71, 86, 88, 98, AL, UC
INCAR-ESO	Incarceration – Emergency Services Only	This benefit plan restricts services to inpatient hospital emergencies only while an otherwise ESO eligible member is incarcerated.	Fee-for-Service	XIX	48 Emergency Services Only
INCAR-MA	Incarceration - MA	A Medicaid-funded benefit plan that restricts services to an off-site inpatient hospital while an otherwise eligible member is incarcerated.	Fee-for-Service	XIX	48
INCAR-MA-E	Incarceration – MA - Emergency Services Only	This benefit plan restricts services to inpatient hospital emergencies only while an otherwise MA-ESO eligible member is incarcerated.	Fee-for-Service	XIX	48 Emergency Services Only

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
LTC-EXEMPT	Long Term Care Exempt	Beneficiaries that are excluded from Long Term Care and Support Services because of Divestment, not meeting LOCD or PASARR requirements, or not returning asset verification.	No Benefits	XIX	N/A
MA	Full Fee-for-Service Medicaid	Members are generally assigned to this benefit plan upon approval of their eligibility information and remain active even if eventually assigned to MA Managed Care (MA-MC). Once assigned to a Managed Care Organization, the health plan is the primary payer.	Fee-for-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan is not assigned for DOS)
MA-ESO	Medical Assistance Emergency Services Only	Individuals who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). [2]	Fee-for-Service	XIX	1, 47, 48, 50, 86, 88, 91, 92, MH, UC Emergency Services Only
MA-FTW	Freedom to Work	Freedom to Work is available to a client with disabilities, age 16 through 64, who has earned income. The client must be disabled according to the disability standards of the Social Security Administration, except employment, earnings, and substantial gainful activity (SGA) cannot be considered in the disability determination. The client must be employed. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary. FTW coverage is retained when a participant is relocated due to employment.	Fee-For-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan is not assigned for DOS)

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
MA-HMP	Healthy Michigan Plan	This plan provides health care benefits to adults 19 through 64 years of age, not covered by or eligible for Medicaid, with family incomes at or below 133% of the federal poverty level (FPL) and who are not eligible for or enrolled in Medicare. Eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology.	Fee-for-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC
MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Individuals who do not meet the Healthy Michigan Plan citizenship requirements to be eligible for full coverage may be eligible for Emergency Services Only (ESO).	Fee-for-Service	XIX	1, 47, 48, 50, 86, 88, 91, 92, MH, UC Emergency Services Only
MA-HMP-INC	Healthy Michigan Plan Incarceration	This program restricts services to an inpatient hospital setting while an otherwise Healthy Michigan Plan eligible member is incarcerated.	Fee-for-Service	XIX	48
MA-HMP-MC	Healthy Michigan Plan - Managed Care	This capitated program provides benefits to the Healthy Michigan Plan members through enrollment in a Medicaid Health Plan (MHP). Certain services not covered under this plan could be covered through MA-HMP Fee-for-Service.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC
MA-MC	Medicaid - Managed Care	Full Medicaid for Managed Care Organization enrollment. This capitated plan will be set to a higher priority than MA (Fee-for-Service). Some services not covered under this plan could be covered in MA.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
MA-MIChild	MIChild Program (CHIP)	MA-MIChild is a Medicaid program administered by the Department of Health and Human Services (MDHHS). It is for the low income uninsured children of Michigan's working families. Like Healthy Kids, MIChild is for children who are under age 19. Members are generally assigned to this benefit plan upon receipt of their eligibility information and remain active even if eventually assigned to MA Managed Care (MA-MC). Once assigned to a Managed Care Organization, the health plan is the primary payer.	Fee-for-Service	XXI	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan is not assigned for DOS)
MIChild-ESO	MIChild Program – Emergency Services Only (CHIP)	Benefits mirror HK-EXP-ESO. Aliens who are not otherwise eligible for full coverage because of citizenship status may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP.[2]	Fee-for-Service	XXI	1, 47, 48, 50, 86, 88, 91, 92, MH, UC Emergency Services Only
MI Choice-MC	Home and Community Based Waiver Services - Managed Care	The MI Choice Waiver is a managed care program that provides home and community-based services for aged and other disabled adults who meet the nursing facility level of care. The program's goal is to provide long-term services and supports that allow persons to remain at home or similar community-based settings. These persons qualify for nursing facility services but choose to receive services in their home. MI Choice beneficiaries are eligible to receive Medicaid state plan services but are excluded from enrollment in a Medicaid Health Plan.	Managed Care Organization	XIX	42
MME-MC	Medicaid-Medicare Dually Eligible – Managed Care	Managed Care Organization enrollment for beneficiaries with dual Medicare and full Medicaid eligibility.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
MOMS	Maternity Outpatient Medical Services	The Maternity Outpatient Medical Services (MOMS) program provides immediate health coverage for the unborn child of an undocumented pregnant woman. The MOMS program is available to provide immediate prenatal care. Prenatal health care services will be covered by MOMS for the entire pregnancy and for two calendar months after the pregnancy ends. Family Planning Services and supplies are covered under this plan using State of Michigan General Funds.	Fee-for-Service	XXI, GF	47, 48, 50, 69, 82, 88, 98, BU
NEMT	Non-Emergency Medical Transportation	This benefit plan provides Non-Emergency Medical Transportation (NEMT) for MA covered services. The NEMT benefit plan is administered by MDHHS through a contractor and is available in selected counties. NEMT for services covered by the Medicaid Health Plan is provided under the Medicaid Health Plan Benefit Plans (MA-MC, MME-MC, and CSHCS-MC).	Managed Care Organization	XIX	56
NH	Nursing Home	This benefit is for qualifying members residing in a nursing home. A facility or institution must be licensed, certified, or otherwise qualified as a nursing home or long term care facility by the state in which services are rendered. This term includes skilled, intermediate, and custodial care facilities which operate within the terms of licensure.	Fee-for-Service	XIX	54
PACE	Program All-Inclusive Care for Elderly	This program is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible. PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 54, 71, 86, 88, 98, AL, MH, UC

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
Plan First	Plan First Family Planning Benefit	Plan First is a limited benefit plan for the coverage of family planning and family planning-related services. Benefits include contraceptive services and supplies, sexually transmitted infection screening and treatment services, elective sterilization procedures, and other reproductive health services.	Fee for Service	XIX	82
PRTF	Psychiatric Residential Treatment Facility	The PRTF benefit provides mental health treatment to children and adolescents who, due to a mental illness, substance abuse, or severe emotional disturbance, need treatment that can effectively be provided in a residential treatment facility. This benefit offers a short term (90-180 days), intense, focused mental health treatment to promote a successful return of the youth to the community. This benefit is clinically driven to address the behavior health needs of individuals that can be diverted from state hospitalization or are stepping down from state hospitalization.	Fee for Service	XIX	RT
QDWI	Qualified Disabled Working Individual	A client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted Premium-free Part A and whose SSA disability benefits ended because the client's earnings exceed SSA's gainful activity limits. Medicaid pays the client's Medicare Part A premium only.	No Benefits	XIX	N/A
QMB	Qualified Medicare Beneficiary – All Inclusive	This benefit plan is part of the Medicare Savings Program (MSP), also known as the "Buy-In" program. A client must be entitled to Medicare Part A. Under certain income limits, Medicaid pays for Medicare Part B premiums, deductibles and co-insurance. This is an all-inclusive benefit plan.	Fee-for-Service	XIX	N/A

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
SED-MC	Serious Emotional Disturbances Managed Care	The Waiver for Children with Serious Emotional Disturbances (SEDW) provides services that are enhancements or additions to Medicaid state plan services for children under age 21. The SEDW is a statewide managed care program. The SEDW enables Medicaid to fund necessary home and community-based services for eligible children with a serious emotional disturbance who meet admission criteria for psychiatric hospitalization.	Managed Care Organization	XIX	N/A
SLMB	Specified Low Income Medicare Beneficiary	A client must have applied for or be enrolled in Medicare Part A. Under certain income limits, Medicaid pays the client's Medicare Part B premium only; Expanded Specified Low-Income Medicare Beneficiary (ESLMB): A client must have applied for or be enrolled in Medicare Part B and not be eligible for any other Medicaid coverage. Under certain income limits, Medicaid pays the client's Medicare Part B premium only. No specific benefits are defined for this plan.	No Benefits	XIX	N/A
Spend-down	Medical Spend-down	If the individual's net income is over the Medicaid limit, the amount in excess is established as a "spend-down amount." In order for the person to qualify for Medicaid during the months, he/she must incur medical bills equal to the spend-down amount. Medicaid will pay expenses incurred above this amount. If a group member is liable for bills incurred before the spend-down period began, these bills can be used to meet the spend-down.	No Benefits	XIX	N/A
SPF	State Psychiatric Hospital	This benefit plan allows claims adjudication for offsite inpatient medical care provided to beneficiaries who are between the ages of 22 and 64 and otherwise reside in a State Psychiatric Facility.	Fee-for-Service	XIX	48

Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source[1]	Covered Services (Service Type Codes)
TCM-INC	Targeted Case Management-INCAR	This benefit plan is assigned to beneficiaries 18 years of age and older who were recently released from an incarcerated setting and is set for one year for the provision of targeted case management services (TCM). The services include an initial comprehensive assessment, development of a care plan, referral and related activities, monitoring and follow-up activities.	Fee for Service	XIX and XXI	CQ
TCMF	Targeted Case Management	The benefit describes Targeted Case Management (TCM) services provided to pregnant women and children up to age 21 with household income up to and including 400% of the federal poverty level (FPL) who were served by the Flint water system on or between April 1, 2014 and the date the water is deemed safe by the appropriate authorities. Pregnant women will remain eligible throughout their pregnancy and will receive two months of post-partum coverage. Once eligibility has been established for a child, including those children born to pregnant women, the child will remain eligible until age 21 as long as other eligibility requirements are met. TCM services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, coordination, referral, monitoring, and follow-up activities.	Fee-for-Service	XIX and XXI	CQ

[1] Social Security Act Title V, Title XIX, Title XXI, and/or State of Michigan General Funds

[2] For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part.

2.2 Program Enrollment Type (PET) Codes

Program Enrollment Type (PET) codes identify a beneficiary's type of admission or managed care enrollment along with their living arrangement.

The PET code will be reported in the Benefit Plans section (EB05 segment) of the CHAMPS eligibility response, along with the applicable Benefit Plan, as additional information for providers if a beneficiary has an admission or Managed Care enrollment on file for the requested date of service. Providers will utilize the Benefit Plan ID(s) indicated in the EB05 segment to determine a beneficiary's program coverage and related covered services for a specific date of service.

Program Enrollment Type (PET)	Program/Reason	Benefit Plan
EXM-ALJD	Long Term Care Exempt ALJD	LTC-EXEMPT
EXM-DIVM	Long Term Care Exempt for Divestment	LTC-EXEMPT
EXM-MPRR	Long Term Care Exempt MPRO	LTC-EXEMPT
EXM-PASR	Long Term Care Exempt PASR	LTC-EXEMPT
HKD-MCDN	Healthy Kids Managed Care Dental	HK-Dental
HOS-COMM	Hospice in the Community	Hospice
HOS-NFAC	Hospice in Nursing Facility	Hospice
HOS-RESD	Hospice in Residence Facility	Hospice
ICO-CMCF	MI Health Link residing in County Medical Care Facility	ICO-MC
ICO-COMM	MI Health Link and living in the community	ICO-MC
ICO-HCBS	MI Health Link and receiving Home and Community Based Services	ICO-MC
ICO-HOSC	MI Health Link receiving Hospice in CMCF	ICO-MC
ICO-HOSH	MI Health Link receiving Hospice at home	ICO-MC
ICO-HOSN	MI Health Link receiving Hospice in a Nursing Facility (not CMCF)	ICO-MC
ICO-HOSR	MI Health Link receiving Hospice in a Hospice Residence Facility	ICO-MC
ICO-HOSW	MI Health Link receiving Home and Community Based Services and receiving Hospice services at home	ICO-MC
ICO-NFAC	MI Health Link residing in Nursing Facility (not CMCF)	ICO-MC
INC-JAIL	Incarceration Jail	INCAR-ESO INCAR-MA INCAR-MA-E MA-HMP-INC
INC-JDET	Incarceration Juvenile Detention	INCAR-ESO INCAR-MA INCAR-MA-E MA-HMP-INC
INC-PRSN	Incarceration Prison	INCAR-ESO INCAR-MA INCAR-MA-E MA-HMP-INC

Program Enrollment Type (PET)	Program/Reason	Benefit Plan
LTC-CMCF	Nursing Facility residing at County Medical Care Facility (CMCF)	NH
LTC-NFAC	Nursing Facility (not CMCF)	NH
LTC-NFAC	Long Term Care (In Hospital) Swing Bed	NH
MHP-CMCF	Medicaid Health Plan and residing in County Medical Care Facility (CMCF)	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MHP-COMM	Medicaid Health Plan	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MHP-HOSH	Medicaid Health Plan and receiving Hospice at home	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MHP-HOSN	Medicaid Health Plan and receiving Hospice in a Nursing Facility	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MHP-HOSR	Medicaid Health Plan and receiving Hospice in a Hospice Residence Facility	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MHP-NFAC	Medicaid Health Plan and residing in a Nursing Facility	CSHCS-MC MA-HMP-MC MA-MC MME-MC
MIC-COMM	MI Choice in the Community	MIChoice-MC
MIC-CSSP	MI Choice in the Community with Significant Support Participant Indicator	MIChoice-MC
MIC-HOSH	MI Choice receiving Hospice at home	MIChoice-MC Hospice
MIC-HSSP	MI Choice Significant Support Participant (SSP) receiving Hospice at home	MIChoice-MC Hospice
PCE-CMCF	PACE and residing in County Medical Care Facility (CMCF)	PACE
PCE-COMM	PACE living in the Community	PACE
PCE-HOSC	PACE receiving Hospice at County Medical Care Facility	PACE
PCE-HOSH	PACE receiving Hospice at home	PACE
PCE-HOSN	PACE receiving Hospice in a Nursing Facility (not CMCF)	PACE
PCE-HOSR	PACE receiving Hospice at Hospice Residence Facility	PACE
PCE-NFAC	PACE residing in Nursing Facility (not CMCF)	PACE
SPF-INPT	State Psych Facility	SPF
TCM-INCR	Targeted Case Management (INCAR)	TCM-INC

2.3 Patient Pay Information

Patient pay is the beneficiary's financial liability. It is shown in whole dollars only and is provided in the CHAMPS eligibility response if the amount is on file for the DOS (e.g., 00050 is $50.00, not 50 cents; 1285 is $1,285.00; or 0 (zero) indicates no patient pay amount). This amount applies to inpatient hospitals, nursing facilities (including ICF/IIDs), and hospice while in a nursing facility. (Refer to the Patient Pay Amount Section of this chapter for more information.)

2.4 Special Programs – Beneficiary Identification

Benefit Plan ID	Program/Eligibility Type
ALMB (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate "**No Records Found.**"	Additional Low-Income Medicare Beneficiary (ALMB) Q1 – Medicaid pays the Medicare Part B premium provided funding is available
BMP	Benefits Monitoring Program
MA (Benefit Plan will be on file once the spend-down is met.)	Medicaid Spend-down met
MA-ESO, MA-HMP-ESO, or HK-EXP-ESO	Limited Medicaid Coverage (Medicaid only covers emergent/urgent services)
MA-MC, MA-HMP-MC	Beneficiary enrolled in a Medicaid Health Plan
QDWI (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate "**No Records Found.**"	Qualified Disabled Working Individual (QDWI) - Medicaid pays the Medicare Part A premium
QMB	Qualified Medicare Beneficiary (QMB) Only - Medicaid pays Medicare Part B premiums, coinsurance, and deductibles
SLMB (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate "**No Records Found.**"	Specified Low Income Medicare Beneficiary (SLMB) – Medicaid pays the Medicare Part B premium
Spend-down (No coverage exists and no card issued.)	Medicaid Spend-down not met
Spend-down & MSP (Medicare Savings Program) (No Medicaid coverage exists. Once the spend-down amount is met, the 'MA' Benefit Plan will be on file.)	Medicaid Deductible not met with QMB

SECTION 3 – VERIFYING BENEFICIARY ELIGIBILITY

The **mihealth** card does not contain eligibility information and does not guarantee eligibility. The provider can use the **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS prior to rendering services.

3.1 CHAMPS ELIGIBILITY INQUIRY

Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry
- HIPAA 270/271 (Eligibility Inquiry/Response) transactions
- Web-based options

(Refer to the Directory Appendix for contact and website information.)

Beneficiary information is confidential under federal guidelines and must be used only for verifying beneficiary eligibility. If the beneficiary is eligible, the following information is available from the eligibility response:

- Beneficiary name, beneficiary ID number or MIChild Client Identification Number (CIN), gender, DOB.
- Benefit Plan ID(s) for the date of service (DOS). (Refer to the Benefit Plans subsection for additional information.)
- PET information (including the PET code), Source Provider ID (supplied through MDHHS), National Provider Identifier (NPI), provider name, telephone number, address, and the patient pay amount, if applicable.
- Medicaid Health Plan (MHP) Primary Care Physician (PCP), including the PCP name, telephone number, and NPI. (NOTE: Data is provided only if the date of service is the current date and a PCP record is on file.)
- Third-Party Liability (TPL), including the payer name, payer ID, coverage type code, group number, policy number, and policyholder ID.
- CSHCS restriction data, including qualifying diagnosis code(s) and authorized provider list if the provider submitting the inquiry is authorized for the DOS.

  NOTE: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) diagnosis codes exist for the date of service.
- Other information: Transaction date (when the data was applied to the Eligibility Subsystem), current county of residence, MDHHS case number, MDHHS worker load number, and local MDHHS office phone number.
- Pending Eligibility (Medicaid-related programs only): Providers will have the option to see if eligibility is pending.

NOTES:

- Dental coverage information is identified by using the Benefit Plan ID data provided in the eligibility response. For Healthy Michigan Plan beneficiaries enrolled in a health plan, dental benefits must be verified through the health plan. (Refer to the Benefit Plans subsection of this chapter and the Enrollment Information subsection of the Dental Chapter for additional information.)

  Note: The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for Medicaid, MIChild and Healthy Kids Expansion beneficiaries who have Fee For Service Dental.
- For Managed Care Organizations (MCOs), beneficiary scope and coverage information is included on the 834 format enrollment files. Additional information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
- The CHAMPS Eligibility Inquiry and 270/271 response will report the HIPAA Service Type code for services covered under each Benefit Plan and any applicable copay amounts. A generic or explicit response will be returned, determined by the type of inquiry (generic or explicit) received through the electronic 270 eligibility request. Always refer to the applicable chapters in this Manual to obtain detailed information on all covered services, including PA requirements, copay amounts/exclusions, and other requirements for the Benefit Plan ID(s) reported in the eligibility response.

Beneficiary eligibility may be queried using the beneficiary ID number or the Client Identification Number (CIN) (for MIChild inquiries only); or, if the ID number is not available, by using one of the following additional search options:

- Beneficiary social security number (SSN) and date of birth (DOB).
- Beneficiary name and SSN (or DOB).

NOTE: Additional search options (use if needed with one of the search options above to obtain a unique member match) include:

- Gender
- Zip Code

Date of Service criteria includes the following:

- Providers can enter a single DOS or up to a 3-month DOS span. (NOTE: DOS is not required for a pending eligibility inquiry since a response is returned if a pending record exists in CHAMPS.)
- Future DOS allowed only up to the end of the current month.
- Providers are allowed to submit a DOS within 12 months of the date of inquiry.

Providers must be enrolled for the DOS in order to receive the eligibility response.

3.2 Accessing CHAMPS Eligibility Inquiry

CHAMPS is a web-based system. Providers should refer to the Eligibility Verification section of the Directory Appendix of this manual for website information.

NOTE: Options require providers to submit their NPI number or CHAMPS Provider ID number (HIPAA Exempt providers only).

3.3 Eligibility Verification for Dates of Service Over 12 Months Old

MDHHS follows CMS guidelines regarding release of eligibility information. An exception is allowed for Hospital providers (Enrollment Type: FAO) to submit DOS older than 12 months for inpatient related services only to complete Medicare DSH audits. Providers must complete the DSH question under the "Manage Provider Checklist" page in the CHAMPS-PE Subsystem and receive approval from MDHHS. To obtain this information, hospitals should refer to the Eligibility Verification section of the Directory Appendix for contact information. There may be a transaction fee charged to the requester for these DSH inquiries.

SECTION 4 – MEDICAID DEDUCTIBLE BENEFICIARIES (SPENDDOWNS)

4.1 ELIGIBILITY

There are cases when beneficiaries have the medical need for Medicaid coverage but they have excess income. These beneficiaries are known as Medicaid deductible beneficiaries. Medicaid deductible means that the beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS worker to qualify for Medicaid. Once the deductible amount has been incurred, the beneficiary becomes eligible for Medicaid benefits (Benefit Plan ID of MA). Providers must verify Medicaid coverage using the Benefit Plan ID(s) provided in the CHAMPS Eligibility Inquiry.

The process for a Medicaid deductible beneficiary to become Medicaid eligible is as follows:

- The beneficiary presents proof of any medical expenses incurred (e.g., insurance premiums, bills for prescriptions and/or office visits) to the MDHHS worker. Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. If the exact charge is not immediately known, providers should estimate the charge on the incurred bill. This expedites the eligibility process.
- The local MDHHS worker reviews the medical bills incurred and determines if the amount of beneficiary liability is met and the first date of Medicaid eligibility.
  - It is fraud to provide beneficiaries with a notice of a bill incurred if no service has been rendered.
  - Bills for services rendered prior to the effective date of Medicaid eligibility are the beneficiary's responsibility.
- For the first date of eligibility, the MDHHS worker sends letters to those providers whose services are:
  - Entirely the beneficiary's responsibility.
  - Partly the beneficiary's responsibility and partly Medicaid's responsibility.
- A letter is also sent to the beneficiary indicating which services are the beneficiary's responsibilities for that first date of Medicaid eligibility.
- The beneficiary's Benefit Plan ID is changed to MA, MA-ESO, or MA-HMP to indicate the Medicaid eligibility period. The provider must verify eligibility using the CHAMPS Eligibility Inquiry when the beneficiary becomes eligible. Once the deductible amount is incurred, eligibility is established through the end of the month.

Providers may bill Medicaid for any covered services rendered during that eligible period**.**

Before billing, providers should verify that the Benefit Plan ID of MA, MA-ESO, or MA-HMP is on file for the DOS. This will assure that the claims will not be rejected for lack of eligibility.

4.2 Retroactive Eligibility

Providers should be aware that, since bills have to be incurred before the deductible amount is met, there is always a period of retroactive eligibility. This may be several days or up to a period of three months from the current month. In this situation, the local MDHHS office may apply these old bills to the past three months or may prospectively apply them to the next several months, depending on the DOS and the date the bill was presented to the MDHHS worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. MDHHS encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider decides to bill Medicaid, they must return all money the beneficiary paid over and above the amount identified as the beneficiary's responsibility on the Medicaid deductible letter. If the beneficiary is accepted as a Medicaid beneficiary, they cannot be charged more than indicated on the letter from the local MDHHS office (plus applicable copayment amounts).

4.3 Billing Instructions

There may be services that are partly the beneficiary's liability and partly Medicaid's liability. If the provider chooses to bill Medicaid for this service, they should refer to the Billing & Reimbursement Chapters of this manual for instructions for submitting claims.

Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible amount. Payment does not have to be made before Medicaid eligibility is approved. Providers may bill a beneficiary for services rendered after a claim rejects for lack of Medicaid eligibility.

(Refer to the Qualified Medicare Beneficiary Section of this chapter for information on Medicaid deductible beneficiaries and Benefit Plan ID of QMB.)

SECTION 5 – CONTRACTUAL CARE ARRANGEMENTS FOR LONG TERM CARE

A **life care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide for all the individual's needs, including health care, for the rest of their life. The individual pays a one-time entrance fee and monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make their monthly payments at a later date. An individual with a life care contract is not eligible for Medicaid.

A **continuing care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide or pay for all, or some of, the individual's medical care for the rest of their life. The individual pays a one-time entrance fee and monthly payments thereafter. An individual with a continuing care contract may be eligible for some Medicaid services.

SECTION 6 – MEDICARE SAVINGS PROGRAM (MSP)

6.1 GENERAL INFORMATION

Federal regulations require that Medicaid purchase Medicare coverage for some beneficiaries and reimburse providers for the Medicare coinsurance and deductible amounts. If these beneficiaries are not also eligible for Medicaid, they have a Benefit Plan ID of QMB. Medicaid only reimburses providers for the Medicare coinsurance and deductible amounts up to the Medicaid maximum amount. Medicaid does not reimburse services not covered by Medicare.

6.2 MEDICAID DEDUCTIBLE BENEFICIARIES (SPENDDOWNS) AND MSP

Beneficiaries may be a MSP and also a Medicaid deductible beneficiary. The beneficiary will have a Benefit Plan ID of QMB until the deductible amount has been met. The Benefit Plan ID will change to MA once the deductible amount is met. For this Medicaid eligibility period, Medicaid reimburses the provider for Medicaid-covered services, as well as the Medicare coinsurance and deductible amounts up to the Medicaid allowable.

If Medicare covers the service, the provider may bill Medicaid for the coinsurance and deductible amounts only. For any Medicare noncovered services, the beneficiary should obtain proof of the incurred medical expense to present to the MDHHS worker so the amount may be applied toward the beneficiary's Medicaid deductible amount.

SECTION 7 – NEWBORN CHILD ELIGIBILITY

A newborn is defined as a child aged 0 (birth) to 1 year old. Generally, Medicaid automatically covers a child born to a woman eligible for and receiving Medicaid at the time of the birth. The mother is required to notify the local MDHHS office of the birth of the newborn within ten days of the birth. (Refer to the Hospital Chapter of this manual for PACER requirements for newborns.)

If the mother is enrolled in a Medicaid Health Plan (MHP) at the time of delivery, the newborn's services are also the responsibility of the MHP unless the child is placed in foster care.

7.1 HOSPITAL NEWBORN NOTICE

In the few cases where this process may be delayed, the hospital's submission of the newborn birth though the State's Electronic Birth Certificate (EBC) system will add the Medicaid coverage and assign a MHP to the newborn. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. If the MSA-2565-C form is used, the local MDHHS office will open the newborn's MA case and return the form to the provider with the necessary billing information.

Eligibility information must be obtained using the CHAMPS Eligibility Inquiry or the HIPAA 270/271 transaction using the newborn ID number provided by MDHHS. The MDHHS Enrollment Services Section should be contacted when the eligibility inquiry does not locate the newborn. (Refer to the Directory Appendix for contact information.) All inquiries must include the following information to assist MDHHS in locating newborn ID numbers:

- Newborn's name (last, first, middle initial)
- Newborn's gender
- Newborn's DOB
- Mother's name (last, first, middle initial)
- Mother's Medicaid ID number
- Requesting person's name and telephone number

7.2 BILLING

When billing MDHHS for medical services rendered to the newborn, providers must use the newborn's Medicaid ID number. The mother's number cannot be used except when the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay. In that situation, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

SECTION 8 – BENEFITS MONITORING PROGRAM

State and federal regulations require the Medicaid program to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to program beneficiaries. The Benefits Monitoring Program (BMP) is in place to closely monitor program usage and to identify beneficiaries who may be over-utilizing and/or misusing their Medicaid services and benefits.

The purpose of the Benefits Monitoring Program is to:

- Promote quality health care;
- Promote patient safety through reduction of drug interaction and/or possible drug abuse, and duplication of medical services;
- Identify beneficiaries whose utilization patterns appear to be overutilization and/or misutilization of their Medicaid benefits;
- Analyze individual beneficiary health service utilization data;
- Improve beneficiary utilization of Medicaid services through educational contacts and monitoring;
- Improve the continuity of care and service coordination to prevent fragmentation of services, and
- Assure that beneficiaries are receiving health care services which are medically necessary and supported by evidence-based practices, thereby curtailing unnecessary costs to the program.

To accomplish these program objectives, the BMP performs the following functions:

- Identifies beneficiaries who appear to be over-utilizing and/or misusing covered services.
- Evaluates utilization of covered services to determine whether the services are appropriate to a beneficiary's medical condition(s).
- Educates beneficiaries regarding appropriate utilization.
- Monitors utilization patterns and institutes interventions to optimize program effectiveness.

The beneficiary may be subject to utilization control mechanisms if it is determined that the beneficiary is overusing and/or abusing Medicaid services. When a beneficiary is enrolled in the BMP, they will remain in the program even as they may move between enrollment in fee-for-service (FFS) and Medicaid Health Plan (MHP) settings. Responsibility for administration of the BMP functions transfers between FFS and MHP settings when a beneficiary's enrollment status changes.

In this chapter, references to responsibilities or actions of the Department mean the Medicaid FFS program or MHP under which the beneficiary is enrolled.

A beneficiary who is enrolled in the BMP will be identified with the Benefit Plan ID of BMP. BMP will be indicated on the CHAMPS Eligibility Inquiry response as additional information.

8.1 Definitions

The following definitions pertain to terminology used specific to the Benefits Monitoring Program and should not be used for interpretation of material found elsewhere in the Medicaid Provider Manual.

Beneficiary	An individual eligible to receive medical assistance through MDHHS.
Benefits Monitoring Program (BMP)	A program to control utilization in which a beneficiary who has been found to engage in misutilization is placed to allow the Department to monitor and assure the medical necessity of services for that beneficiary.
BMP Authorized Provider	A provider who has been approved to render services to a beneficiary enrolled in the Benefits Monitoring Program by MDHHS or MHP BMP staff. Active BMP Authorized Providers are contained in the CHAMPS Eligibility Inquiry response as additional information.
Emergency Medical Condition	Federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: ▪ Place the person's health in serious jeopardy; or ▪ Cause serious impairment to bodily functions; or ▪ Cause serious dysfunction of any bodily organ or part.
Medicaid Health Plan (MHP)	MDHHS contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries.
Medical Assistance Program	The Department's program to provide for medical assistance established by Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being S400.105 of the Michigan Compiled Laws, and Title XIX of the federal Social Security Act, 42 U.S.C. S1396 et seq.
Misutilization	The use of medical assistance in excess of, or inappropriate to, the particular medical needs of the beneficiary as determined by the Department through investigation and analysis. Initial indicators of possible misutilization in light of a beneficiary's medical condition shall include, but are not limited to, unusually frequent physician, pharmacy or emergency department visits, frequent use of ambulance and/or non-emergency medical transportation services, and unusually frequent acquisition of drugs subject to abuse.
Negative Action	Action by the Department (or MHP) to discontinue, terminate, suspend, or reduce public assistance or services.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which has been approved to provide medical assistance to a beneficiary pursuant to the Medical Assistance Program.
The Department	The Michigan Department of Health and Human Services (MDHHS)

8.2 BMP Enrollment Criteria

The criteria in the following subsections are used to identify beneficiaries to be placed in the BMP. Enrollment in the BMP is determined after review of the beneficiary's usage of medical services. Beneficiaries may be enrolled in BMP when any of the following criteria (alone or in combination) are present.

8.2.A. Fraud

The beneficiary is suspected, or has been convicted, of fraud for one or more of the following:

- Selling or purchasing products/pharmaceuticals obtained through Medicaid.
- Altering prescriptions to obtain medical services, products or pharmaceuticals.
- Stealing prescriptions/pads; provider impersonation.
- Using another individual's identity to obtain medical services, products or pharmaceuticals.

8.2.B. Misutilization of Emergency Department Services

Criteria include, but are not limited to, the following:

- More than three emergency department visits in one quarter.
- Repeated emergency department visits with no follow-up with a primary care provider (PCP) or specialist when appropriate.
- More than one outpatient hospital emergency department facility in one quarter.
- Repeated emergency department visits for non-emergent conditions.

8.2.C. Misutilization of Pharmacy Services

Criteria include, but are not limited to, the following:

- Utilizing more than three different pharmacies in one quarter.
- Aberrant utilization patterns for drug categories listed in the Drug Categories subsection of this chapter over a one-year period.
- Obtaining more than five prescriptions for drug categories listed in the Drug Categories subsection of this chapter in one quarter (including emergency prescriptions).
- Utilizing multiple prescribing providers for drug categories listed in the Drug Categories subsection, including when prescribing providers provide services to the beneficiary as a private pay patient (e.g., beneficiary pays cash for office visits while using the Medicaid pharmacy benefit to obtain prescriptions).

8.2.D. Misutilization of Physician Services

Criteria include, but are not limited to, the following:

- Utilizing more than one physician/non-physician practitioner in different practices to obtain duplicate or similar services for the same or similar health condition.
- Utilizing more than one physician/non-physician practitioner in different practices to obtain duplicate prescriptions for a drug(s) listed in the Drug Categories subsection of this chapter (e.g., two prescriptions for Vicodin/hydrocodone written by different providers within an overlapping timeframe).
- Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.

8.2.E. Other

MDHHS will review additional criteria as misutilization patterns emerge or are identified by the Department.

8.3 Drug Categories

MDHHS considers the following drug categories as having high potential for abuse:

- Narcotic Analgesics
- Barbiturates
- Sedative-Hypnotic, Non-Barbiturates
- Central Nervous System Stimulants/Anti-Narcoleptics
- Anti-Anxieties
- Amphetamines
- Skeletal Muscle Relaxants

8.4 Notification and Enrollment

Notification of enrollment in the BMP is sent to the beneficiary to the address on file with MDHHS. It is the beneficiary's responsibility to report a change of address to MDHHS. This notification includes the following:

- Information regarding the utilization patterns and concerns;
- The enrollment effective date; and
- Instructions on the selection of providers (which must be approved by the Department).

The beneficiary is given 10 calendar days to contact the Department and discuss the findings prior to the enrollment effective date. Enrollment of a beneficiary in a MHP may be determined by the Department or the MHP using approved criteria. Enrollment in the BMP does not constitute a negative action by the Department or the MHP. Enrollment of a beneficiary in the BMP does not suspend, reduce, discontinue,

or terminate any services or assistance that a beneficiary is eligible for at the time of the beneficiary's enrollment in the BMP.

8.5 Benefits Monitoring Program Control Mechanisms

8.5.A. Obtaining Drugs Subject to Abuse

Michigan's Pharmacy Benefits Manager (PBM) processes all point of sale (POS) prescription drug claims for MDHHS. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days.

Beneficiaries in the BMP are prevented from filling or refilling prescribed medications listed in the Drug Categories subsection of this chapter until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals as ordered, and consistent with Medicaid limits.

Additional controls on drugs subject to abuse may be imposed. MDHHS may restrict access to these drug classes through pharmacy and/or prescribing provider assignment. Providers authorized to fill/prescribe drugs subject to abuse are identified by a "Y" indicator in the "Send to PBM" field of the CHAMPS Eligibility Inquiry response, BMP Restrictions page. Refer to the Assigned Providers subsection for additional information.

Drugs subject to abuse ordered in conjunction with exempt services, to include emergency (72 hour) medication supplies, may require communication with the MDHHS PBM and/or BMP program staff. (Refer to the Directory Appendix for contact information.) Refer to the Exempt Services subsection for additional information.

8.5.B. Assigned Providers

The BMP may assign beneficiaries to providers through which covered services can be obtained. BMP Authorized Providers that may be assigned include, but are not limited to, any one or more of the following:

- Specific PCP
- Specific pharmacy
- Specific outpatient hospital
- Specific specialist provider
- Specific group practice

8.5.C. Restricting Benefits

In some cases, the Department may find that a restriction of optional benefits (i.e., pharmacy) is an appropriate intervention. In the event of continued misutilization, as defined in the Definitions subsection and as outlined in the BMP Enrollment Criteria subsection (and its subsections), optional benefits may be reduced in accordance with federal and state regulations. Beneficiaries subject to a benefit restriction will receive

written notice of the action, the effective and end dates applicable, and appeal information.

8.5.D. Exempt Services

Services exempt from the BMP include, but are not limited to, the following:

- Emergency services
- Dental services
- Services rendered by a nursing facility provider
- Services rendered in an inpatient hospital
- Hospice services
- Optometry services
- Community Transition Services
- Home Help services

Although these services are exempt, controls on drugs subject to abuse are maintained in MDHHS information systems and will impact the beneficiary's ability to obtain certain pharmaceutical services using Medicaid benefits. Refer to the Obtaining Drugs Subject to Abuse subsection for additional information.

8.6 Monitoring and Review

Beneficiaries are placed in the BMP for a minimum of 24 months. The utilization of medical services and drugs is routinely monitored and the effectiveness of the BMP interventions is evaluated. The Department shall review the placement at least once every 24 months.

8.7 Provider Responsibilities

8.7.A. All Providers

Eligibility must be verified before providing service. BMP enrollees are indicated on the CHAMPS Eligibility Inquiry Response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restrictions page which contains the BMP FFS and Managed Care Authorized Provider information.

When the beneficiary has FFS eligibility, the information in the BMP FFS Authorized Providers table directs payment. If there are no providers listed in the BMP FFS Authorized Providers table, the beneficiary is restricted only by the pharmaceutical refill tolerance for that date of service. The BMP may be contacted for additional information regarding covered services.

FFS reimbursement for BMP enrollees is limited to exempt services, services provided by an active BMP Authorized Provider per the beneficiary's eligibility file, and services provided by a referred provider when the following are present:

- The beneficiary was referred by an active BMP FFS Authorized Provider; and
- The referred provider has obtained a current Benefits Monitoring Program Referral (form MSA-1302) from the BMP FFS Authorized Provider.

Rendering (and referring, when applicable) provider NPI numbers are required on claim submissions.

When the beneficiary is enrolled in a MHP, the information in both the BMP FFS and Managed Care Authorized Providers tables is applicable. For FFS payment of services carved out of the MHP benefit, providers must be listed in the BMP FFS Authorized Providers table. The "Send to PBM" field must have a "Y" indicator for the prescribing physician for FFS payment of drugs subject to abuse which are carved out of the MHP benefit. The MHP may be contacted for additional information regarding covered services.

8.7.B. BMP Authorized Providers

The BMP assigns Authorized Providers who are responsible for supervising the case management and coordination of all prescribed drugs, specialty care, and ancillary services. These responsibilities encompass patient-centered care and do not amount to separate reimbursement. Reimbursement for any ambulatory service will not be made unless the service was provided, referred, prescribed, or ordered by the PCP and the claim includes the appropriate information.

The beneficiary may participate in the PCP and other provider assignment processes, both initially and through request for changes to established BMP Authorized Providers. If the Department has reason to suspect that a beneficiary's provider selection will not contribute to a reduction in utilization and/or be appropriate to the beneficiary's health condition(s), the selection may be denied. If the beneficiary fails to respond to the Department with provider selections, the Department may assign providers without beneficiary participation.

Written notice of provider assignments will be mailed to the beneficiary and the provider. When applicable (e.g., Department assigned providers, denial of request to change providers), appeal information and instructions will accompany written notice.

MDHHS reserves the right to end/terminate provider authorization for a BMP enrollee at any time. A replacement provider may be assigned following such an action. Instances will be determined on a case-by-case basis following periodic review, and must meet at least one of the following criteria:

- A review of utilization reveals that a provider is not contributing to a reduction in service utilization (including use of drugs subject to abuse) as defined by the BMP;
- The BMP Authorized Provider becomes a sanctioned provider; or
- The BMP Authorized Provider makes referrals to the emergency department for non-emergent conditions.

8.7.C. Referrals for BMP Enrollees

The BMP Authorized Provider must complete a MSA-1302 when referring a BMP enrollee for other specialty services. This form applies to beneficiaries with Medicaid FFS program eligibility. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)

8.7.D. Discharge from Practice

It is the responsibility of the BMP Authorized Provider to notify the Department when a BMP enrollee is discharged from their practice. General practice standards should be followed with regard to patient notification. Written communication informing the beneficiary of the intent to sever the relationship and/or the MSA-1302 indicating "discharge from practice" may be sent to the Department to satisfy this responsibility.

8.7.E. Referrals to BMP

To report potential misutilization of services, contact the MDHHS Benefits Monitoring Program. (Refer to the Directory Appendix for contact information.)

8.7.F. Beneficiary Fraud

Suspected beneficiary fraud should be referred to the MDHHS Office of Inspector General. (Refer to the Directory Appendix for contact information.)

8.8 Changes in Enrollment

A beneficiary enrolled in the BMP will remain in the BMP for the minimum time period regardless of any change in enrollment status (e.g., change from fee-for-service to managed care, break in eligibility, incarceration, etc.). When a beneficiary in the BMP has a change in enrollment, responsibility for monitoring the beneficiary moves from the Department to the MHP or vice versa.

When a beneficiary has a break or change in eligibility that disrupts historical data collection and review, upon regaining full Medicaid eligibility, the beneficiary will, by default, remain in the BMP and periodic review will depend on availability of sufficient utilization data.

8.9 Termination of BMP Enrollment

When the beneficiary's utilization has been determined to be at an appropriate level or there is a change in medical status, the Department may terminate the beneficiary's enrollment in BMP.

8.10 Appeals

Any written notice of a negative action or denial of a beneficiary's provider choice shall include reference to the beneficiary's right to appeal. The appeal process shall conform to Michigan Administrative Code (MAC) Rules R400.901 to R400.922.

The MHP is the respondent in BMP-related hearings pertaining to actions taken by the MHP.

SECTION 9 – MEDICAID HEALTH PLANS

MDHHS contracts with health plans in the state. The Medicaid Health Plans (MHPs) are paid a monthly capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The MHP is responsible for providing, arranging, and reimbursing most medical services.

9.1 ENROLLMENT

Within the Medicaid population, there are groups that:

- Must enroll in a MHP.
- May voluntarily enroll in a MHP.
- Are excluded from enrollment in a MHP.

Mandatory Enrollment	▪ Most people who are receiving full Medicaid benefits. ▪ People receiving Medicaid who participate in the Children's Waiver or the Habilitation Supports Waiver. ▪ Supplemental Security Income (SSI) beneficiaries who do not receive Medicare. ▪ Pregnant women whose pregnancy is the basis for Medicaid eligibility. **The newborn child is automatically enrolled in that health plan. Health plan responsibilities begin at the time of the child's birth. (Refer to the Newborn Child Eligibility Section of this chapter for more information.)**
Voluntary Enrollment	▪ Migrants ▪ Native American Indians of Federally recognized tribes ▪ Most people who are dually Medicare/Medicaid eligible
Excluded Enrollment	▪ People without full Medicaid coverage (they receive emergency services only). ▪ People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB). ▪ People with Medicaid who reside in an ICF/IID or state psychiatric hospital. ▪ People in the MDHHS Brain Injury Services transitional residential program.

- People receiving nursing facility services. (Refer to the Excluded Health Plan Services subsection of this chapter for additional information.)
- Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program.
- People being served under the MI Choice Waiver.
- People enrolled in the CSHCS Program without full Medicaid coverage.
- Medicaid Deductible beneficiaries. (Refer to Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)
- People with commercial managed care coverage. This includes beneficiaries enrolled in a Medicare health plan which is not approved to provide Medicaid service in their county.
- People in PACE (Program of All-Inclusive Care for the Elderly).
- People enrolled in the Plan First Family Planning benefit plan.
- Children in child caring institutions.
- People in the Refugee Assistance Program.
- People in the Repatriate Assistance Program.
- People who have been disenrolled from a Medicaid Health Plan.
- People receiving Private Duty Nursing Services. All beneficiaries enrolled in a health plan will be disenrolled retroactively to the first day of the month in which the PDN services are received.

If one member of a family resides in a nursing facility or loses Medicaid eligibility, this does not exempt the other family members from enrollment in a health plan.

9.2 MICHIGAN ENROLLS

Beneficiaries who are eligible to enroll in a MHP are covered for Medicaid services on a FFS basis until enrolled in a health plan.

Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, "Choosing Your Health Plan", which provides them information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. The beneficiary has 90 days after assignment of or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period.

MDHHS has contracted with MI Enrolls to:

- Inform beneficiaries which physicians, pharmacies, and hospitals are part of each health plan.

- Provide information to help the beneficiary choose a primary provider (a physician, nurse practitioner (NP), or physician's assistant who manages all of the beneficiary's health care).
- Answer beneficiary questions regarding how to use the health plan.
- Enroll beneficiaries in the health plan they choose, or automatically enroll them in a health plan.
- Change the beneficiary's health plan.
- Provide a Request for an Administrative Hearing and Instructions form (DCH-0092).
- Provide a Medical Exception Request form (MSA-1628) for medical exception from Managed Care.
- Provide a Beneficiary Complaint form (MSA-0300).
- Provide the Special Disenrollment–For Cause Request form (MSA-0176).

(Refer to the Directory Appendix for MI Enrolls contact information.)

9.3 Medical Exceptions to Mandatory Enrollment

The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (MD or DO) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:

- The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- The condition stabilizes and becomes chronic in nature, or
- The physician becomes available to the beneficiary through enrollment in a MHP.

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

9.3.A. Definitions

Serious Medical Condition	Grave, complex, or life threatening. Manifests symptoms needing timely intervention to prevent complications or permanent impairment. An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.

Chronic Medical Condition	Relatively stable. Requires long term management. Carries little immediate risk to health. Fluctuates over time but responds to well-known standard medical treatment protocols.
Active Treatment	Active treatment is reviewed in regards to intensity of services when: ▪ The beneficiary is seen regularly, (e.g., monthly or more frequently), and ▪ The condition requires timely and ongoing assessment because of the severity of symptoms and/or the treatment.
Attending/Treating Physician	The physician (MD or DO) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.
MHP Participating Physician	A physician is considering participating in a MHP if they are in the MHP provider network or are available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with a MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.

9.3.B. Process for Requesting a Medical Exception

The Medicaid beneficiary must initiate the review process for medical exception by completing Section I of the Medical Exception Request (form MSA-1628). Beneficiaries can obtain forms, discuss managed care options, or ask questions regarding the medical exception process by contacting MI Enrolls. (Refer to the Directory Appendix for contact information.) If the beneficiary has been enrolled in a MHP for more than two months, the medical exception request does not apply.

9.3.C. Physician Responsibility

The physician who is actively treating the beneficiary for the serious medical condition must complete Section II of the MSA-1628. If multiple physicians are involved, each one must complete a separate form. The physician completing the form must be actively treating the beneficiary, and must not be participating with or have any arrangement with a MHP with which the beneficiary can be enrolled. The information provided by the physician must include:

- A detailed description of the serious medical condition that is being treated, including the diagnosis and current active signs and symptoms in adequate detail to justify the degree of seriousness. Diagnosis alone is not sufficient.
- The length of time that the beneficiary has been actively treated for this condition by the physician completing the form.

- The treatment plan in place, including any planned interventions and a list of all current and anticipated medications.
- The frequency of visits.
- The anticipated length of time (in months) that the beneficiary will need this treatment.

A Medical Exception Request cannot be processed without all of the above information. MDHHS will verify that the treating physician is not available in any MHP in which the beneficiary can be enrolled. If an exception to managed care enrollment is granted, the MDHHS will identify a period of time, up to one year, for which it is approved. At the end of that period, the beneficiary will be eligible for enrollment in a MHP.

9.4 CHAMPS Eligibility Inquiry

The CHAMPS Eligibility Inquiry transaction indicates the following for a beneficiary in a MHP:

- Benefit Plan ID of MA-MC, MA-HMP-MC, CSHCS-MC, or MME-MC
- MHP name, telephone number and address
- MHP Primary Care Physician (PCP), including the PCP name, telephone number, and NPI. (NOTE: Data is provided only if the date of service is the current date and a PCP record is on file.)

9.5 Health Plan Membership

Once enrolled in a health plan, that health plan sends member information to the beneficiary. The CHAMPS Eligibility Inquiry will indicate the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC, or MME-MC, including the MHP name and toll-free telephone number as additional information. The beneficiary also receives a membership card from the health plan.

9.6 Covered Health Plan Services

Services may be provided directly by the health plan or arranged through the health plan. Coverages include current Medicaid-covered services and any additional services the health plan may decide to provide that may not be Medicaid-covered services, other than excluded services listed below.

9.7 Excluded Health Plan Services

Services are either included or excluded from the health plan's monthly capitation rate. The following services are not included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.

- Dental custodial services for Healthy Kids Dental eligible beneficiaries. (Oral-maxillofacial surgeons providing medical services are included in the health plan's capitation rate and should follow health plan authorization rules.) Adult dental benefits are included in MHP capitation rates.
- Nursing facility (NF) custodial services. The health plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be

Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.

Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. If a beneficiary is in a facility prior to enrollment in a MHP and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the MHP and set the nursing facility PET.

Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).

- Substance abuse treatment services.
- Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
- Personal care authorized through MDHHS.
- School-based services.
- Pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.
- Drugs in the categories listed on the MHP carve-out list are excluded from the MHP contract. (Refer to the Directory Appendix for website information.)
- Private Duty Nursing (PDN) services.

9.8 Health Plan Authorizations

The health plan must provide or arrange for services covered by the plan. Services that are not covered by the health plan do not require the health plan's authorization. If providers render both a health plan covered and a health plan noncovered service, the health plan is responsible for providing/arranging and reimbursing for those health plan covered services. It is imperative that health plan providers obtain authorization from the health plan for plan-covered services.

For Medicaid-covered services:

- Non-emergency care – health plan authorization is required before rendering the service.
- Urgent care – health plan authorization is required before rendering the service.
- Emergency care to the point of stabilization – no authorization is required. The health plan is responsible for reimbursement of the service. The provider must inform the health plan as soon as possible that emergency services were provided. Post-stabilization treatment requires health plan authorization before rendering the service.

If a service requires PA from a health plan and from MDHHS (e.g., cosmetic surgery), the provider must obtain the authorization from the health plan but does not have to obtain a second PA from MDHHS.

9.9 Copayments

Health plan beneficiaries may be charged a copayment for physician, dental and outpatient hospital evaluation and management visits, non-emergency visits to the emergency department, the first day of an inpatient hospital stay (except for emergent admissions), and pharmacy, podiatric, chiropractic, vision, or hearing services as described in this manual. Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.

(Refer to the Dental Chapter of this manual for additional information.)

9.10 Billing

9.10.A. Health Plan Members

The health plan receives a monthly capitation fee for each Medicaid beneficiary enrolled in the plan as part of its contract with MDHHS. Health plans and providers may not bill the beneficiary for services not authorized by the health plan unless the beneficiary was informed of their financial responsibility prior to receiving the service. Providers may bill Medicaid for a service that is excluded from the health plan contract, but Medicaid covered under FFS.

9.10.B. Referral Providers

If the health plan refers a beneficiary to a provider for health plan covered services, the health plan is responsible for reimbursement of those services.

9.10.C. Health Plan as a Private Insurance (Other Insurance Code 89)

A beneficiary who has an existing private health plan through employment, spouse or other source cannot be enrolled in a MHP at the same time. MDHHS disenrolls that beneficiary from the MHP.

There may be FFS beneficiaries who are enrolled with a health plan as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private health plan policy (such as Blue Care Network).

The monthly capitation payment must not be reflected on the Medicaid claim. In most instances, the provider is billing Medicaid for the copayment amount only. Medicaid only reimburses the provider for the Medicaid fee screen or copayment amount, whichever is less. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If Medicaid's maximum allowable amount is less than the copayment amount billed, the beneficiary or their representative may not be billed for the difference. The amount paid by Medicaid is considered as payment in full.

SECTION 10 – CHILDREN'S SPECIAL HEALTH CARE SERVICES

MDHHS BPHASA determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:

- Persons under the age of 26 with one or more qualifying medical diagnoses.
- Persons age 26 and older with cystic fibrosis, hereditary coagulation defects commonly known as hemophilia, or hereditary red blood cell disorders commonly known as sickle cell disease.

Medical eligibility must be established by MDHHS before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of other CSHCS criteria. An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Healthy Michigan Plan, Medicare or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and all eligibility criteria for the other applicable program.

10.1 COVERAGE

The CSHCS coverage is limited to specialty health care services for the treatment of the beneficiary's qualifying medical condition. CSHCS does not cover primary care, well child visits or immunizations. Those with additional coverage (e.g., Medicaid, MIChild) continue to receive their well child visits, immunizations, etc. through that source or coverage.

Dental interventions may be covered for certain qualifying diagnoses. Beneficiaries must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be related to the qualifying diagnosis and authorized by CSHCS.

CSHCS does not cover the treatment service needs related to developmental delay, intellectual disability, autism, psychiatric, emotional, behavioral or other mental health diagnoses. A beneficiary who has both CSHCS and Medicaid or CSHCS and MIChild benefits receives their Medicaid or MIChild covered mental health services from the local PIHP/CMHSP.

CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and FFS Medicaid or CSHCS and MIChild benefits receives their Medicaid or MIChild covered substance abuse treatment services from the regional PIHP. A beneficiary who has CSHCS and is enrolled in a Medicaid Health Plan may receive outpatient mental health visits through the Medicaid Health Plan. Provision of outpatient mental health services through the Medicaid Health Plan is available pursuant to the Beneficiary Eligibility subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter.

10.2 IDENTIFYING CSHCS ON THE CHAMPS ELIGIBILITY INQUIRY

The eligibility response will indicate when a beneficiary is enrolled in CSHCS for the date of service (DOS) entered in the inquiry. It will also identify if the provider NPI number entered is authorized to render CSHCS services for the beneficiary on that DOS. Providers will receive the Benefit Plan ID of CSHCS with one of the following messages in the eligibility response:

- This NPI is listed. See CSHCS guidelines.
  This message means the NPI is authorized by CSHCS to render services to this beneficiary on the specified date(s) of service. Services must be related to the beneficiary's CSHCS qualifying diagnosis.

  Note: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) codes exist for the date of service.
- This NPI is not listed. See CSHCS guidelines.
  This message means the NPI is not authorized to render services to a CSHCS beneficiary on the specified date(s) of service. Some providers can render services to a CSHCS beneficiary without being authorized.

Refer to the Approved/Authorized Providers Section of the Children's Special Health Care Services Chapter of this manual for authorized provider information.

10.3 Beneficiary Reviews

Beneficiaries may request a Department Review for denial of eligibility determinations/redeterminations and denial of services. They may contact their local health department (LHD) or the CSHCS Program through the CSHCS Family Center. (Refer to the Directory Appendix for contact information.)

SECTION 11 – APPLICATION FOR MEDICAL ASSISTANCE

If a person is potentially eligible for health care coverage, excluding CSHCS, but has not applied for assistance, an application form should be completed. If the person is unable to complete the application form and a relative, guardian, or other representative of choice is not available to complete the form on their behalf, then the hospital or NF may do so.

The Application for Health Coverage & Help Paying Costs form (DCH-1426) is used for potential beneficiaries. The form may be obtained from the local MDHHS office or is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The Medicaid Patient of Nursing Home Application (DHS-4574) may be used as an alternative to the DCH-1426. The DHS-4574 is a Medicaid application/redetermination form used to determine Medicaid eligibility for the nursing facility patient only.

The application forms are self-explanatory. Questions regarding the forms should be referred to the local MDHHS office.

11.1 HOSPITALS AND NURSING FACILITIES

The individual or their authorized representative should sign applications when possible. The local MDHHS office must determine Medicaid eligibility even if the individual is receiving Supplemental Security Income (SSI) benefits. An individual is not automatically eligible for Medicaid just because they have SSI benefits and reside in a nursing facility.

For state-owned and -operated facilities, if the individual is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using their personal signature and position title.

If retroactive Medicaid eligibility is requested, in addition to the application form, the Retroactive Medicaid Application (DHS-3243) must be completed for each retroactive month that eligibility is requested.

11.2 INITIAL ASSESSMENT OF ASSETS

The local MDHHS office must make an Initial Asset Assessment for a married resident in a nursing facility (even if not currently applying to Medicaid) or for a married individual who is applying for the MI Choice Waiver or the PACE program. The assessment must be made from the first day of continuous care received by the applicant/individual.

An initial assessment is a determination of the total amount of countable assets owned by an institutionalized or MI Choice waiver patient and/or their spouse on a given day. The day is usually the day the patient was admitted to the NF or MI Choice waiver.

Nursing facilities are required to notify patients, their families, or authorized representatives of the need to request the initial assessment in case of future Medicaid application. The Asset Declaration - Nursing Home Resident and Spouse (FIA-4574B), is to be completed by the patient and submitted to the local MDHHS office to request that an initial assessment be completed. The facility may assist the patient with

the completion of this form. Any questions regarding the form, or requests for copies of the form, should be directed to the local MDHHS office.

The patient may refuse to complete the assessment, but it should be stressed that it is easier to obtain the assessment at the time of admission than it is to try to recreate the situation at a future date.

SECTION 12 – ELIGIBILITY DETERMINATION OF INSTITUTIONAL CARE

Nursing facilities, hospitals, state-owned and –operated facilities, CMHSP facilities, hospice, MI Choice Waiver, and MI Health Link agencies must enter beneficiary admissions, transfers, and discharges directly in CHAMPS. A completed admission will assign a PET code and benefit plan. Alternatively, when a discharge is completed in CHAMPS, the beneficiary's PET code and benefit plan will end date to reflect the discharge date. The admission or discharge should be submitted even if Medicare or other insurance covers the person's stay.

When completing an admission via CHAMPS, the facility must print the admission/enrollment form generated by CHAMPS and continue to obtain the potential beneficiary (or their authorized representative) signature on the form. The signature of the facility personnel completing the admission form must also be obtained. This signed form must be retained in the beneficiary's record. If the facility has a signature on file, that should be noted in the signature box.

In the event a beneficiary is admitted to a subsequent facility and the previous facility did not discharge the beneficiary, the new admission created in CHAMPS by the second facility will automatically discharge the beneficiary from the previous facility one day before the new facility admission date. The previous facility will receive an alert in CHAMPS that the beneficiary was discharged so they can modify the discharge date if needed (for example, if the beneficiary was discharged a week earlier before going to the second facility).

When a beneficiary is discharged, the facility must discharge the beneficiary via CHAMPS to avoid any access to care problems for the beneficiary in the community (e.g., durable medical equipment, medical supplies).

Hospice note: For Medicaid beneficiaries residing in a nursing facility and receiving hospice services when the beneficiary is discharged from hospice (involuntary or voluntary), the NF must complete an admission in CHAMPS to assign the nursing facility PET code and benefit plan. The nursing facility will receive a manual gross adjustment for the date of the admission. Alternatively, if the facility completes the admission in CHAMPS prior to the hospice discharging the beneficiary, the new admission created in CHAMPS will automatically discharge the beneficiary from hospice and the associated PET code one day before the nursing facility admission date.

12.1 PATIENT PAY AMOUNT

12.1.A. NURSING FACILITY DETERMINATIONS

After the Medicaid application has been submitted, the local MDHHS office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income is then considered in determining the amount the beneficiary must pay toward their medical expenses each month. This monthly contribution by the beneficiary toward their care is called the Patient Pay Amount (PPA).

Nursing facilities have the following options to obtain the PPA and eligibility information:

- DHS-3227 – If the local MDHHS office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, the Tentative Patient Pay Amount Notice (DHS-3227) is sent to the facility as notification of the person's tentative PPA.
- Nursing facility's determination of potential PPA – A timely collection of the PPA is vital for nursing facilities as it helps eliminate the need to claim adjust Medicaid and the need to retroactively collect the PPA from the beneficiary. To help alleviate unneeded claim adjusting and to collect a PPA more timely, nursing facilities are encouraged to determine what a potential beneficiary's PPA will be and collect that PPA prior to receiving the DHS-3227. Subsequently, the facility would bill Medicaid showing that potential PPA as determined by the facility.
- CHAMPS Eligibility Inquiry and/or other available eligibility options to obtain the Benefit Plan ID, PET code authorization, facility information and PPA. (Refer to the Directory Appendix for contact and website information.)

CHAMPS Eligibility Inquiry and/or other available eligibility options should be used in the preparation of bills for services provided in that month. This avoids many billing problems stemming from eligibility information. The facility may contact the beneficiary's local MDHHS office as identified on the eligibility response if the information provided is incorrect.

The provider should contact MDHHS Provider Inquiry for answers to billing questions. (Refer to the Directory Appendix for contact information.)

Facilities are responsible for collecting the PPA. If the facility receives the DHS-3227, it indicates a tentative PPA to be collected by the facility. In determining the tentative PPA, MDHHS does not prorate for partial months. This amount is subject to change as the beneficiary's financial eligibility changes. The PPA must be exhausted before any Medicaid payment is made.

A beneficiary who has a PPA cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the PPA (even if the PPA is great enough to cover the higher private pay rate). The balance, or unused portion, of the PPA must be returned to the beneficiary or their family.

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to use their PPA to obtain these services. For additional information, the facility may contact MDHHS Long Term Care (LTC) Services. (Refer to the Directory Appendix for contact information.)

12.1.B. Hospitals

Hospitals are not notified of a tentative patient pay amount via the DHS-3227. The hospital may obtain the patient pay amount by:

- The eligibility response. (Refer to the Verifying Beneficiary Eligibility section for additional information.)
- Submitting a claim to MDHHS. (Medicaid deducts the patient pay amount and the claim is processed accordingly.)
- Contacting the local MDHHS office.

12.1.C. State-Owned and -Operated Facilities/PIHPs/CMHSPs

BPHASA or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the MDHHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or their authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.

12.1.D. Excess Patient Pay Amounts

If the provider has an excess patient pay amount and has been billing Medicaid, the provider must return any overpayments made by MDHHS. This must be done using a replacement claim or void/cancel claim. The provider may then use the remaining funds for beneficiary private pay.

12.2 Preadmission Screening

If a beneficiary is to be transferred from an acute care hospital to a NF, preadmission screening for mental illness/intellectual/developmental disability or a related condition must be completed prior to transfer.

COORDINATION OF BENEFITS

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SECTION 1 – INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program (CMHSP), that entity is responsible for the Medicaid payment liability.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Health and Human Services (MDHHS).

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

1.1 SUBROGATION

As a condition of Medicaid eligibility, beneficiaries must assign MDHHS the right to seek recovery of other resource payments made on their behalf. If MDHHS identifies another resource for a paid claim, a bill will be generated to the other resource within the appropriate timely filing guideline. The other resource will reimburse Medicaid directly or reject the paid claim. MDHHS will review other resource rejections to determine if the rejection is appropriate or if the provider can resubmit the claim to the other resource for reimbursement.

1.2 CLAIM VOID PROCESS

MDHHS will send a Pending Claim Void notice via mail and the Archived Documents repository within CHAMPS when it is determined that a provider did not hold another resource liable for payment after Medicaid adjudicated the claim. If the claim was lacking information about the existence of another resource, the provider must resubmit the claim in CHAMPS as an adjustment and include the proper Claim Adjustment Reason Code within 30 days of the date provided on the Pending Claim Void notice. Pharmacy providers must resubmit the claim to the Pharmacy Benefits Manager (PBM) and include the proper Other Coverage Code. Pharmacies must also notify MDHHS within 30 days of the date provided on the Pending Pharmacy Claim Void notice to report the updated claim adjudication. MDHHS will automatically void the claim after the 30 days if no adjustment is made in CHAMPS from medical providers or if no notification is received from pharmacy providers. The provider will then have to bill the identified resource for the claim. It is the provider's responsibility to remediate with the primary payer prior to rebilling Medicaid for the claim.

1.3 Verification of Other Insurance

Information about a beneficiary's other insurance is available through the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS 270/271 transaction. It is not displayed on the **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for additional information.)

Providers should always ask the beneficiary if other insurance coverage exists at the time of service. If the beneficiary identifies other insurance coverage that is not listed in the eligibility response, the provider must use that other insurance and report it to MDHHS by contacting Medicaid Provider Inquiry or by completing the on-line Request to Add, Terminate, or Change Other Insurance (form DCH-0078). If the beneficiary belongs to a network, the provider must refer them to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.)

If the beneficiary does not agree with the other insurance information contained in the eligibility response, (e.g., other insurance coverage is no longer available), the beneficiary should be instructed to notify their local MDHHS office of the change or contact the Beneficiary Helpline to report the change. If the provider elects to initiate a change to the beneficiary eligibility response, the DCH-0078 should be completed. (Refer to the Forms Appendix for a copy of the form and additional instructions.)

The form should be submitted prior to billing Medicaid. If known, providers should include the policy's per diem payment amount or any supplemental information in the comments section of the form. The TPL Section will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The provider should bill the other resource first. Once payment has been received, the provider may bill Medicaid. The Medicaid claim must include the payment amount received from the other resource.

SECTION 2 - CATEGORIES OF OTHER INSURANCE

The major categories of other insurance are:

- Commercial health insurance carriers (i.e., managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO], long-term care [LTC] insurance policies), traditional indemnity policies, and military/veteran insurance (i.e., TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA]).
- Auto Insurance (accident, no-fault)
- Workers' Disability Compensation
- Court-Ordered Medical Support
- General Liability Insurance
- Medicare

2.1 COMMERCIAL HEALTH INSURANCE, TRADITIONAL INDEMNITY POLICIES, AND MILITARY/VETERAN INSURANCE

If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed. This includes, but is not limited to:

- Prior authorization (PA) requirements.
- Provider qualifications.
- Obtaining services through the insurer's provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the primary health insurance coverage.

PA is not necessary for situations of other insurance coverage if all of the following apply:	**PA is required for the following:**
▪ The beneficiary is eligible for the other insurance and the primary insurer rules are followed; ▪ The provider is billing a standard Healthcare Common Procedure Coding System (HCPCS) code that Medicaid covers, and the primary insurer makes payment or applies the service to the deductible; and ▪ The service/item complies with Michigan Medicaid standards of coverage as described in this manual.	▪ PA is required for cases where the other insurance benefit has been exhausted or the service/item is not a covered benefit. ▪ PA is necessary for all other situations, including not otherwise classified (NOC) codes.

Inappropriately recoded claims are rejected by MDHHS even if MDHHS issued PA.

MDHHS payment liability for beneficiaries with other insurance is the lesser of the beneficiary's liability (including coinsurance, copayments, or deductibles), the provider's charge minus contractual adjustments, or the maximum Medicaid fee screen minus the insurance payments. For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment-in-full for services rendered. Neither the beneficiary nor MDHHS has any financial liability in these situations.

Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDHHS Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

Insurance companies should not submit checks directly to Medicaid. Rather, providers must work directly with the insurance company or the beneficiary to obtain the insurance payment. If the insurance company pays the beneficiary directly, it is the provider's responsibility to obtain the payment from the beneficiary; if the policyholder is someone other than the beneficiary, it is the provider's responsibility to obtain the payment from the policyholder.

2.2 Automobile Insurance (Accident, No-Fault)

Under Michigan's no-fault law, drivers may choose various levels of personal injury protection (PIP) coverage as part of their automobile insurance coverage. The automobile insurance carrier is required to pay the medical expenses for injuries incurred in an automobile accident consistent with the level of PIP coverage selected by the insured. In some instances, the insured's automobile policy contains a rider stating that their health insurance coverage takes priority over the automobile insurance carrier's policy. (This also applies to Coordination of Benefits riders.) In situations where more than one individual is involved in an accident, there is a possibility that multiple automobile insurance carriers are involved. As a result, the liable insurance carrier cannot always be readily identified at the time of initial medical treatment. The no-fault law is designed to designate an order of priority of liability. Providers must bill

the automobile insurance carrier prior to billing Medicaid or the Medicaid managed care plan. Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

The order of responsibility to pay for medical expenses for automobile accidents is as follows:

- The insurance company of the injured party, regardless of whether they were in their, or any, automobile.
- The insurance company of any resident relative of the house in which the injured party also resides.
- The insurer of the owner of the vehicle occupied. For nonoccupants (pedestrians) of the vehicle, the insurer of the vehicle involved.
- The insurer of the driver of the vehicle occupied. For nonoccupants (pedestrians) of the vehicle, the insurer of the driver involved.

Providers may directly pursue no-fault or other casualty cases and submit claims directly to the other insurance carriers. The automobile insurance carrier must be billed within 12 months from the date of the accident in order to preserve the right of recovery under the no-fault statute.

If liability is in question, Medicaid may be billed. If benefits associated with the auto insurance coverage are exhausted, the provider may bill Medicaid for Medicaid covered services consistent with the beneficiary's benefit plan. Medicaid or the Medicaid managed care plan pursues reimbursement from the other insurance through subrogation. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.

2.3 Workers' Disability Compensation

Workers' Disability Compensation is a system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment. Workers' Disability Compensation does not cover medical care incidental to or separate from the injury. Providers must establish if the beneficiary is covered by Workers' Disability Compensation. Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

If a claim has been filed and is contested, providers may bill Medicaid while the claim is pending resolution by Workers' Disability Compensation. The provider must bill the appropriate procedure code, the date the claim was submitted (if known), and any other pertinent information (e.g., employer, Workers' Disability Compensation carrier, and attorney's name). Medicaid or the Medicaid managed care plan may bill the compensation carrier, or may follow up in hearings as to redemption or settlement. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.

2.4 Court-Ordered Medical Support

Court-ordered medical support is medical coverage for beneficiaries that the court has ordered to be paid by an individual (who is also the policyholder) other than the beneficiary. This individual could be an absent parent, a grandparent, adoptive parent, etc. The provider must pursue recovery of the other insurance payment directly from the policyholder. In instances where the policyholder does not reside

with the beneficiary (e.g., an absent parent), providers are encouraged to have the custodial parent obtain a Qualifying Medical Support Order through the local Friend of the Court. This allows the provider to bill the other insurance directly (e.g., Blue Cross/Blue Shield). If there is not a Qualifying Medical Support Order on file for the beneficiary, providers must still obtain the other insurance payment from the policyholder. (Refer to the Directory Appendix for contact information.)

2.5 General Liability

General liability insurance is coverage that generally pertains to claims arising out of the insured's liability for injuries or damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, or the operation of machinery, as well as professional services. If the beneficiary's injury is not work - or automobile-related, the beneficiary's medical services may be covered by another insurance carrier (e.g., homeowner's insurance policy). This insurance carrier is considered primary and must be billed according to the rules of the insurance carrier.

2.6 Medicare

2.6.A. Medicare Eligibility

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.

Medicaid beneficiaries who are eligible for Medicare due to age, but not enrolled in Medicare Part A or Part B, will have claims paid by Medicaid for Medicaid covered services. Medicaid will only pay claims for services that fall under the Medicare Part for which the beneficiary is eligible, but not enrolled. The provider must bill Medicare for covered services when the beneficiary only has Part A or Part B. After the beneficiary obtains Medicare, affected claims will be voided and the provider must bill Medicare. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.

2.6.B. Medicare Part A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

For QMBs, if MDHHS is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDHHS also pays the beneficiary's Medicare Part A premium.

MDHHS monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDHHS automatically processes Part A buy-in.

To expedite the buy-in process, providers may notify MDHHS, in writing, when a beneficiary covered by Medicare Part B only is admitted to an inpatient hospital. (Refer to the Directory Appendix for MDHHS Provider Inquiry contact information.)

The following information is required:

- Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- Medicare Beneficiary Identifier (MBI) or Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and provider NPI number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
- To bill a claim when no Medicare payment has been made because the amount of Medicare coinsurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

2.6.C. Medicare Part B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, MDHHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

2.6.D. Medicare Part D

Beneficiaries enrolled in Medicare Part A and/or Part B are eligible for Medicare Part D. Medicaid does not pay for Medicare Part D covered drugs for Medicare enrolled beneficiaries.

Medicaid will cover some of the drugs which are excluded from Part D. (Refer to the Pharmacy chapter for drug product coverage information.)

Medicaid does not cover Part D drugs for beneficiaries who are enrolled in Medicare Part A and/or Part B and elect to opt out of a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.)

All questions regarding Part D coverage should be directed to Medicare. (Refer to the Directory Appendix for contact information.)

2.6.E. Medicare Buy-In/Medicare Savings Program

If a beneficiary is eligible for Medicare but has not enrolled, they can do so at any time throughout the year by applying with SSA. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the Medicare Buy-In Agreement) with the federal government. However, Medicaid cannot buy-in for the beneficiary until they apply for Medicare and the SSA is aware that they are Medicaid-eligible, and the beneficiary has applied for the Medicare Savings Program through their local MDHHS office. Beneficiaries eligible for Buy-In but who have not enrolled in Medicare can enroll at any time throughout the year by applying with SSA. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment. Beneficiaries who need to enroll in Medicare can visit their nearest Social Security office for assistance or contact the Michigan Medicare/Medicaid Assistance Program (MMAP) for health benefit information and counseling. (Refer to the Directory Appendix for contact information.)

Some dual-eligible beneficiaries are classified as:

Qualified Medicare Beneficiaries (QMB)	Medicaid pays Medicare Part A and Part B premiums for these individuals, and reimburses providers for Medicare coinsurance and/or deductible amounts only to the extent that the total payment does not exceed the Medicaid maximum allowable amount. These beneficiaries are identified by the Benefit Plan ID of QMB in the eligibility response. Physicians and suppliers should be aware that services provided to QMBs are reimbursed on a Medicare assignment basis only. If a provider knowingly bills for Medicare services on other than an assignment basis, the U.S. Department of Health & Human Services (HHS) can seek sanctions.
Specified Low Income Medicare Beneficiaries (SLM/SLMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse providers for any services rendered to the beneficiary. No **mihealth** card is issued to these individuals.
Additional Low Income Medicare Beneficiaries (ALMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse the provider for any services rendered to the beneficiary. No **mihealth** card is issued to these individuals.

2.6.F. Medicaid Liability

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDHHS pays fixed copays (except Medicare Part D) on the services up to the lesser of Medicaid's allowable amount minus the Medicare payment for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

MDHHS reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. MDHHS payment liability for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of:

- The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The provider's charge, minus any Medicare or other insurance payments, contractual adjustments, and any applicable Medicaid copayment, patient-pay, or deductible amounts.

Claims submitted by providers with a Medicare Cost Share enrollment type will only adjudicate if Medicare is reported primary for these providers. Claims submitted for

reimbursement of Medicaid primary services will deny for Medicare cost-sharing only providers. Billing, rendering, attending, ordering, and referring provider types reported on these cost-sharing claims must be enrolled either as a Medicare Cost Share or full Medicaid provider.

For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

MDHHS does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDHHS will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements.

Common noncompliance denials include, but are not limited to,:

- Failure to obtain a referral from a participating primary care provider (PCP).
- Failure to be seen by a participating provider.
- Failure to be seen in a participating place of service.
- Failure to obtain a second opinion.
- Failure to obtain prior authorization

In instances where MDHHS has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.

NOTE: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed – Claim Not Covered." When the National Council for Prescription Drug Programs (NCPDP) standard does not provide MDHHS with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDHHS will review and recover monies for noncompliance on a post-payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDHHS is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and/or Part D, MDHHS will pay claims for Medicare Part B or Part D services. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

MDHHS identifies fee-for-service (FFS) beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. FFS providers are notified by MDHHS when these adjustments occur. The notification includes beneficiary detail. If a discrepancy in payment exists, the provider should contact Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP capitation. Refer to the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance subsection of this chapter for exceptions when a beneficiary has third party resources.

2.6.G. Exceptions to the Timely Filing Billing Limitation

When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within one year of the date of payment, rejection or retroactive recovery of funds by Medicare. Medicaid payment is made provided all other requirements (e.g., beneficiary eligibility, medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the Remarks segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

2.6.H. Lifetime Reserve Days

Medicare allows a one-time additional 60 days of coverage known as Lifetime Reserve Days (LRD). A Medicaid beneficiary who has Medicare Part A must use these 60 days before Medicaid makes a payment, except for deductibles and coinsurance.

2.6.I. Outpatient Hospital Laboratory Services

Medicare pays most diagnostic and clinical laboratory tests at 100 percent. Therefore, Medicaid has no payment liability.

2.6.J. Psychiatric Services

Diagnostic outpatient hospital psychiatric physician services, including the initial psychiatric diagnostic and evaluation interview, family counseling and psychological testing, are reimbursed as a Medicare Part B service.

2.6.K. Other Insurance Payer ID

Other Insurance Payer IDs can be accessed in CHAMPS by individual beneficiary. All third-party carriers must be used to the fullest extent possible, prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs, including Medicaid Health Plans (MHPs) and PIHPs/CMHSPs/CAs.

SECTION 3 - SPECIAL CONSIDERATIONS

3.1 MASTER MEDICAL

All insurance coverage, including Master Medical policy riders, must be used before filing a claim with Medicaid. If the beneficiary has a Master Medical policy rider (e.g., Blue Cross/Blue Shield), providers must identify whether the provider or policyholder must bill. If the policyholder must bill, the provider must provide a statement of charges to the beneficiary or policyholder to use when billing Master Medical. If there is a court order for medical support that includes Master Medical, the custodial parent may obtain a qualified medical support order for providers to be paid directly from the insurance carrier. Whether the payment is made to the policyholder or the provider, the provider must report it as other insurance payment on the bill submitted to Medicaid. Providers must pursue recovery of the insurance payment if it is made directly to the policyholder. The beneficiary, or their representative, must not be billed for this payment unless the beneficiary is the policyholder.

3.2 HOSPITAL CREDIT BALANCE REFUND PROCESS

A TPL hospital credit balance refers to funds that must be returned to MDHHS because a claim has been paid by another resource or paid incorrectly.

Providers must refund credit balance overpayments by submitting claim adjustments or claim voids through CHAMPS or submitting them via an electronic claim vendor. Providers are required to include a comment on the claim adjustment or claim void that reads "Credit Balance MM/DD/YYYY" where MM/DD/YYYY is the date the overpayment was identified.

Providers are required to resolve credit balances before submitting their fiscal year end cost report. Any credit balances adjusted through CHAMPS prior to the MDHHS designated contractor's audit need not be reported to the contractor. For credit balance adjustments performed via CHAMPS, the provider's documentation must match the identification date noted in the claim adjustment or claim void comments within CHAMPS.

3.3 COINSURANCE/DEDUCTIBLE AND/OR COPAYMENT

Medicaid responsibility for payment of coinsurance/deductible and/or copayment amounts is:

Coinsurance, Copayments, and Deductibles	Medicaid pays the appropriate coinsurance amounts, copayment amounts, and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by another insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

MDHHS cannot be billed for copays, coinsurance, deductibles, or any fees for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/CMHSP capitation.

Beneficiaries are responsible for payment of all copays and deductibles allowed under the MHP/PIHP/CMHSP contract with MDHHS. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP capitation, the MHP/PIHP/CMHSP assumes the Medicaid payment liabilities.

Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP capitation.

(Refer to the Medicaid Liability subsection of this chapter for additional information on Medicare claims.)

3.4 Claim Replacement

A claim replacement should be submitted if another insurance makes a payment subsequent to Medicaid's payment. (For specific claim replacement instructions, refer to the Billing & Reimbursement Chapters of this manual.)

3.5 Claims Subject to Additional Edits

If a beneficiary has Medicare or private insurance, submitted claims must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered, prescribed or referred the service(s)/item(s). If the applicable attending, ordering, prescribing or referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

3.6 Exceptions to Medicaid Payer of Last Resort

There are a few exceptions to the general rule that Medicaid is the payer of last resort. In limited circumstances where there is a federal statute making Medicaid primary to a specific program, the Medicaid program must pay before the federally-administered health program.

The following federally-administered programs are some examples of exceptions to Medicaid's payer of last resort rule:

- Crime Victims Compensation Fund
- Ryan White Program
- Indian Health Services
- Women, Infants and Children Program
- Grantees under Title V of the Social Security Act (Maternal and Child Health Services Block Grant)
- Veteran Benefits – emergency treatment provided in a non-VA facility
- Veteran Benefits – non-VA nursing home per diem payments

SECTION 4 – CROSSOVER CLAIMS

The crossover process allows providers to submit a single claim for individuals dually eligible for Medicare and Medicaid, or qualified Medicare beneficiaries eligible for Medicaid payment of coinsurance and deductible to a Medicare fiscal intermediary, and also have it processed for Medicaid reimbursement. Refer to the specific claim type chapters within this manual for further billing instructions.

Additional information about the crossover claim process is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.1 ACCEPTABLE CROSSOVER CLAIMS

MDHHS accepts Medicare Part A institutional claims (inpatient and outpatient) and Medicare Part B professional claims processed through the CMS Coordinator of Benefits Contractor, Group Health, Inc. (GHI). Claim adjudication will be based on the provider NPI number reported on the claim submitted to Medicare.

When a claim is crossed over to MDHHS, a remittance advice (RA) will be generated from the fiscal intermediary with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the fiscal intermediary's RA, a separate claim will have to be submitted to MDHHS.

4.2 CLAIMS EXCLUDED FROM CROSSOVER PROCESS

The following types of claims will be **excluded** from the crossover process between MDHHS and Medicare:

- Totally denied claims
- Claims denied as duplicates or missing information
- Replacement claims or void/cancel claims submitted to Medicare
- Claims reimbursed 100 percent by Medicare
- Claims for dates of service outside the beneficiary's Medicaid eligibility begin and end dates

Providers must resolve denied claims with the fiscal intermediary unless the service is an excluded benefit for Medicare, but covered by Medicaid (e.g., insertion of an IUD or hearing aid supply). In those cases, the excluded Medicare service can be billed directly to MDHHS.

Additional information regarding crossover billing and exclusions can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

BILLING & REIMBURSEMENT FOR DENTAL PROVIDERS

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SECTION 1 – GENERAL INFORMATION [CHANGE MADE 7/1/2025]

This chapter applies to all providers billing the ADA **(text deleted 7/1/2025)** or 837 Dental claim formats. It contains information needed to submit dental claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDHHS actions.

Dental providers must use the ASC X12N 837D 5010 dental format when submitting electronic claims and the ADA **(text deleted 7/1/2025)** claim form for paper claims.

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. Electronic claims received by Wednesday may be processed as early as the next weekly cycle.

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal (DMP) available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.

1.3 CLAIM PAYMENT/CLAIM STATUS

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)

To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)

SECTION 2 – GENERAL INFORMATION/PRIOR AUTHORIZATION

The Dental Prior Approval Authorization Request (MSA-1680-B) is a form designed to obtain authorization for those services that require prior authorization (PA), as indicated in the Dental Chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

The dental provider must remember the following:

- Radiographs must be sent along with the PA form and are returned only upon provider request.
- The PA form only needs to include the procedure that requires PA.
- Assess the general oral health and provide a five-year prognosis on the prosthesis requested.
- The dental provider should make liberal use of the Pertinent Dental History and Medical areas on the request to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. When health problems exist, they should be identified on the request along with any effect they might have upon the proposed plan of treatment.
- Any additional documentation submitted with the request must contain the beneficiary's name and identification (ID) number, date, and the dental provider's name and NPI number.

Additional information is generally required to be submitted with or indicated on the PA form. This is to enable staff to make an accurate determination regarding the proposed plan of treatment.

SECTION 3 – HOW TO FILE CLAIMS

Dental claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

3.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837D 5010 dental format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

3.1.A. AUTHORIZED BILLING AGENT

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA compliant MDHHS standards, and submit the files to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA) that reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

3.1.B. ELECTRONIC CLAIMS WITH ATTACHMENTS

The Document Management Portal in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for

Medicaid electronic claims. (Refer to the MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required, providers must use the Document Management Portal. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal process allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for the Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

Submission of electronic attachments via fax requires the use of a fax cover sheet which will be generated in the DMP system. (Refer to the MDHHS website for information on the Document Management Portal. Refer to the Directory Appendix for website information.)

3.2 Paper Claims [Change Made 7/1/2025]

The ADA **(text deleted 7/1/2025)** claim form must be used when submitting paper claim forms. The MDHHS Optical Character Reader (OCR) scans paper claims.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn-out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

3.2.A. Guidelines to Complete Paper Claim Forms [Change Made 7/1/2025]

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- American Dental Association (ADA) standard completion instructions should be followed in completing the ADA **(text deleted 7/1/2025)** claim form.
- Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.
- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut the edges of forms.
- Keep the file copy.
- Mail Dental claim forms separately from any other claim form type.

3.2.B. Paper Claims with Attachments

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID Number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

3.2.C. Mailing Paper Claims

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)

3.3 Reporting Provider NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., billing, rendering, referring) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). For a Type 2 (Organization) NPI, both the NPI and EIN must be reported at the billing provider loop for all electronic claims. For a Type 1 (Individual) NPI, both the NPI and EIN/SSN are required at the billing provider loop for electronic claims when a Type 2 NPI does not apply.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Organization) NPI is the number required for organizations such as clinics, group practices, and incorporated individuals who provide health care services and receive payment. For MDHHS, the Organization NPI must be reported in the billing provider loop or field. Also, for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Organization) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the billing, referring, and/or rendering provider as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

The ADA claim form does not contain fields for the referring provider. Paper claims which require this information must be submitted via CHAMPS Direct Data Entry (DDE). (Refer to the Directory Appendix for additional information.)

3.3.A. Billing Provider

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

3.3.B. Rendering Provider

The rendering provider loop or field must be completed within the professional/dental claim formats only when the provider is enrolled with MDHHS. For an organization (such as clinics and group practices), the rendering provider will be required. If MDHHS does not recognize the rendering provider's NPI, services rendered by these providers (e.g., dental therapist, dental hygienists) must be billed under the supervising dentist's NPI. The supervising dentist is responsible for ensuring the medical necessity and appropriateness of the services.

3.3.C. Referring Provider

Referring provider information is a claim editing requirement for services rendered as a result of a referral. The claim must contain the name and individual NPI of the provider who referred the service(s)/item(s).

If referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement. Referring providers may initiate the enrollment process at any time. (Refer to the General Information for Providers chapter for information regarding enrollment.)

SECTION 4 – ADA COMPLETION INSTRUCTIONS

4.1 DENTAL CLAIM FORM COMPLETION INSTRUCTIONS [CHANGE MADE 7/1/2025]

American Dental Association (ADA) standard completion instructions should be followed in completing the ADA **(text deleted 7/1/2025)** claim form.

SECTION 5 – SPECIAL BILLING INSTRUCTIONS

5.1 SUPERNUMERARY TEETH [CHANGE MADE 7/1/2025]

Providers bill the appropriate procedure code and the supernumerary tooth number as identified using the ADA Universal/National Tooth Designation System. Supernumerary Permanent teeth are identified by the numbers 51 through 82, beginning with the upper right third molar, following the upper arch and continuing on the lower arch, concluding with the lower right third molar area in the same manner as permanent tooth numbers 1 through 32. For example, tooth number 51 would correlate with the position of tooth number 1 and tooth number 82 would correlate with the position of tooth number 32.

Refer to the **(text deleted 7/1/2025)** ADA Claim form instructions for additional information.

5.2 LOSS OR CHANGE IN ELIGIBILITY

Services are not covered after loss or change in eligibility. Root canal therapy, authorized laboratory processed crowns, and authorized complete and partial dentures may be reimbursed if services were started prior to the loss/change in eligibility and completed within the month following the last date of eligibility.

Electronic Claims	Treatment Start Date and Treatment Completion Date are required within Loop 2400 DPT.
DDE Claims	Treatment Start Date and Treatment Completion Date are required within the appropriate DDE fields.
Paper Claims	For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be entered in the Remarks section). For root canal therapy, the date of service should be the first treatment appointment (the completion date must be entered in the Remarks section).

5.3 INCOMPLETE PROCEDURES

When root canal treatment, authorized laboratory processed crowns or authorized denture services have commenced but extenuating circumstances have prevented completion (e.g., beneficiary death), providers are paid a reduced rate to offset a portion of the costs incurred. A request to amend the original PA must be submitted as described below. Refer to the Dental chapter of this manual for PA requirements.

5.3.A. INCOMPLETE CROWN

- Providers must bill procedure code D2999.
- Date of service is the date of the impression.
- Include the PA number on the claim.

5.3.B. Incomplete Root Canal

- Providers must bill procedure code D3999.
- Date of service is the date of the first treatment appointment.
- Include the PA number on the claim.

5.3.C. Incomplete Denture or Partial Denture

- Providers must bill procedure code D5899.
- Date of service is the date of the initial impression.
- Include the PA number on the claim.

5.4 Diagnosis Reporting

Diagnosis reporting is required for all oral and maxillofacial surgical procedures, anesthesia and IV sedation services. ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available.

Electronic Claims	The diagnosis code(s) is required to be reported in Loop 2300 HI.
DDE Claims	The diagnosis code(s) is required in the applicable DDE diagnosis field.
Paper Claims	The diagnosis code(s) is required in the Remarks section.

5.5 Quantity

The Quantity field is available for use for both electronic (Loop 2430 SVD/DVD05) and DDE claims to report the number of dental services rendered. The quantity for dental code D0230 (Intraoral periapical, each additional film) is required for proper claim adjudication.

5.6 Orthodontic Billing Instructions

5.6.A. Limited Orthodontic Treatment

For limited orthodontic treatment, submit a single claim for the entire limited treatment phase.

- The date of service is the banding/start date.
- Include the PA number on the claim.
- Reimbursement is made for the entire treatment time period and is considered payment in full.

5.6.B. Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment procedure codes are used in the first stage of each comprehensive treatment phase.

Billing instructions for comprehensive orthodontic treatment are as follows:

- The date of service is the banding insertion date.
- Include the PA number on the claim.

An initial payment is made with a claim submission using the comprehensive orthodontic procedure code and subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code

5.6.C. Periodic Orthodontic Treatment

Billing instructions for periodic orthodontic treatment are as follows:

- The date of service is the first day of the six-month treatment period.
- The date of service cannot be the same as the banding insertion date.
- Include the PA number on the claim.
- The beginning and end dates for the entire time period should be entered in the Remarks section of the claim.
- If treatment ends prior to the completion of the six-month time period, the fee for the treatment time frame must be pro-rated.
  - The date of service is the first day of the periodic treatment time period.
  - Include the PA number on the claim.
  - The fee charged should reflect the treatment time period (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee).
  - The entire pro-rated time period is entered into the Remarks section of the claim.

When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full.

5.7 Interim Caries Arresting Medicament

CDT D1354 - Interim Caries Arresting Medicament Application is billable once per date of service regardless of the number of teeth treated up to a maximum of five (5) teeth per visit. Providers are required to enter the tooth number(s)/letter(s) of all teeth treated in the comments section of the claim. There is a maximum of six applications per lifetime. Silver Diamine Fluoride can be billed on the same date of service as other fluoride applications.

SECTION 6 – REPLACEMENT CLAIMS

6.1 GENERAL INFORMATION

Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDHHS has made payment. Both the provider NPI and beneficiary ID numbers on the replacement claim must be the same as on the original claim. Reasons claims may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim such as changing the date of service, tooth number or incorrect charges;
- To correct an incorrect provider NPI number or beneficiary ID number (refer to the void/cancel process below);
- To report payment from another source after MDHHS paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

If all service lines on a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

6.2 CLAIM REPLACEMENT AND VOID/CANCEL CLAIMS

Instructions for submitting an electronic replacement claim are contained in the MDHHS 837D Companion Guide available on the MDHHS website. (Refer to the Directory Appendix for website information.)

A void/cancel claim must be submitted if the original claim was paid under the incorrect provider ID or beneficiary ID number.

Providers using the paper dental claim form to submit a void/cancel claim must submit a new claim. Only one service line needs to be completed with zero dollars entered in the charges or money field. All money paid on the first claim line will be deleted. Upon notification through the Remittance Advice that the money has been deleted from the Medicaid system, a new claim with the correct provider NPI number and/or beneficiary ID may be submitted.

Replacement and void/cancel claims must be sent to the address noted in the Directory Appendix for that purpose. They are not to be sent to the address utilized for initial claims.

6.3 PAYMENT REFUNDS

Return of overpayments made by MDHHS, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund
- include the provider EIN (tax) number
- be sent to MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit a replacement claim and manually send a refund to the Cashier's Unit as this results in an incorrect refund amount.

SECTION 7 – CHANGES IN ELIGIBILITY AND ENROLLMENT (FFS/CSHCS)

7.1 GENERAL INFORMATION

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid or Children's Special Health Care Services (CSHCS) beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

7.2 BILLING REQUIREMENTS

Providers must use the date of delivery when billing for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures and laboratory-processed crowns, the provider has 30 days from the change in/loss of eligibility to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns, or the first treatment appointment for root canal therapy.

SECTION 8 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider enrollment agreement. An RA is issued with each payment to explain the payment made for each claim. If no payment is due or claims have rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for DMB website information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems.
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment.
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim.
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.

For more information regarding the 835 these transactions. The guides are available through the Washington Publishing transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for Company. (Refer to the Directory Appendix for contact information.)

8.3 Paper Remittance Advice

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

8.4 Gross Adjustments

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

8.5 Claim Adjustment Reason/Remark Codes

When claims are initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits that apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.

SECTION 9 – JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to the number of days after February 28. The next three leap years are 2028, 2032 and 2036.

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).

BILLING & REIMBURSEMENT FOR INSTITUTIONAL PROVIDERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to providers billing the NUBC or 837 institutional claim formats. It contains information needed to submit institutional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs and Children's Special Health Care Services (CSHCS). It also explains how claims are processed and how providers are notified of MDHHS actions.

The following providers must use the ASC X12N 837 5010 institutional format when submitting electronic claims and the NUBC claim form for paper claims.

- Home Health Agencies
- Hospice
- Hospital
- Nursing Facilities
- Outpatient Therapy Providers*
- Private Duty Nursing Agencies

* Comprehensive Outpatient Rehabilitation Facilities, Outpatient Rehabilitation Agencies, CARF-Accredited Medical Rehabilitation Programs, CAA-Accredited University Graduate Education Programs

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. MDHHS uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated. Electronic claims submitted by Wednesday may be processed as early as the next weekly cycle.

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.

1.3 Claim Payment/Claim Status

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)

To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)

SECTION 2 – HOW TO FILE CLAIMS

Institutional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, resulting in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837 5010 institutional format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as Companion Guides, are on the MDHHS website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

2.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA-compliant MDHHS standards and submit the file to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA), which reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

2.1.B. Electronic Claims with Attachments

The Document Management Portal (DMP) in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for Medicaid electronic claims. (Refer to the MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report, history and physical, prior authorization (PA), or other paper attachment is required, providers must use the Document Management Portal through CHAMPS to submit electronic attachments to MDHHS. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal process allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Consent forms (Consent for Sterilization [MSA-1959/HHS-687] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must be submitted through the Document Management Portal. If submitted via facsimile, consent forms must be sent accompanied by the appropriate fax cover sheet. (Refer to the Forms Appendix for copies of the forms and to the Directory Appendix for website information.) MDHHS will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. All consent forms must be submitted through the Document Management Portal.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

2.2 Paper Claims

The National Uniform Billing Committee (NUBC) UB-04 claim form must be used when submitting paper claims. It must be a red-ink form with UB-04 CMS-1450 in the lower left corner. Use of forms other than the red ink version will result in errors when they are scanned by the Optical Character Reader (OCR). Providers are encouraged to bill electronically whenever possible.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned prior to processing, print or alignment problems may cause

misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. Guidelines to Complete Paper Claim Forms

To ensure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to adhere to these guidelines may result in processing/payment delays or claims being returned unprocessed.

- Date of birth must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212002). All other dates must be six digits in the format MMDDYY. Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.

- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correction typewriters.
- If a mistake is made, the provider should start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put a return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail NUBC claim forms separate from any other type of form.

2.2.B. Providing Attachments with Paper Claim Forms

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified on each page with the beneficiary's name and Medicaid ID number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims that have no attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay claim processing.

Claim attachments, such as medical records and EOBs, may be associated to a paper claim via the Document Management Portal. (Refer to the Directory Appendix for website information.)

Once confirmation is received that the consent forms are approved, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via Document Management Portal" must be included in the Remarks section of the paper claim.

Refer to the MDHHS website for Document Management Portal instructions, including fax requirements. (Refer to the Directory Appendix for website information.)

2.2.C. Mailing Paper Claim Forms

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)

2.3 Reporting Provider NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., attending, billing, referring, and rendering) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. Both the NPI and the TIN or Employer Identification Number (EIN) must be reported at the billing provider loop for all electronic claims. For the UB-04 paper claim form, the TIN must be reported in Form Locator 5.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Organization) NPI is the number required for organizations (such as clinics, group practices, and incorporated individuals) who provide healthcare services and receive payment. For MDHHS, the Organization NPI must be reported in the billing provider loop or field. Also for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Organization) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the attending, billing, referring and rendering provider as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

2.3.A. Billing Provider

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

2.3.B. Attending Provider

The attending provider NPI is a requirement for all claims submitted within the institutional claim format with one exception. Hospital-owned ambulance Medicaid-enrolled providers submitting Emergency Ambulance Transport claims may report the attending provider NPI, however, completion of this field is not required. For all institutional claims, the attending provider must be Medicaid enrolled. If the attending provider information is not reported on the claim or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement.

2.3.C. Referring Provider

If a referring provider is required to be submitted, use the appropriate Form Locator field for claim completion.

SECTION 3 – REPLACEMENT, VOID/CANCEL CLAIMS AND REFUND OF PAYMENT

3.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after MDHHS made payment. When replacement claims are received, MDHHS deletes the original claim and replaces it with the information from the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be recouped and payment will be based on information reported on the replacement claim only. Examples of when a claim may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim (other than to correct the provider NPI number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below;
- To report payment from another source after MDHHS paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

To replace a previously paid claim, indicate 7 (xx7) as the third digit in the Type of Bill Form locator frequency. Providers must enter the 18-digit Transaction Control Number (TCN) of the last approved claim being replaced and the reason for the replacement in Remarks. The provider NPI number and beneficiary ID number on the replacement claim must be the same as on the original claim. Providers must enter in Remarks the reason for the replacement. Refer to the Void/Cancel subsection below for additional information.

3.2 VOID/CANCEL A PRIOR CLAIM

If a claim was paid under the wrong provider NPI or beneficiary ID Number, providers must void/cancel the claim. To void/cancel the claim, indicate an 8 in the Type of Bill (xx8) as the third digit frequency. The 8 indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter the 18-digit TCN of the last approved claim or adjustment being cancelled and enter in the Remarks section the reason for the void/cancel. A new claim may be submitted immediately using the correct provider NPI or beneficiary ID number.

A void/cancel claim must be completed exactly as the original claim.

3.3 REFUND OF PAYMENT

Return of overpayments made by MDHHS, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund;
- include the provider EIN (tax) number; and

- be sent to the MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit either a replacement claim or a void/cancel claim and manually send a refund to the Cashier's Unit as this will result in an incorrect amount.

SECTION 4 – CHANGES IN ELIGIBILITY/ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of patients at time of treatment and obtain the appropriate authorizations for payment.

Medicaid or CSHCS beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (FFS Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether PA is necessary.

4.1 MDHHS ADMISSION NOTIFICATION – HOSPITALS

It is vital that hospital providers complete admission/enrollment and discharge/disenrollment information in a timely manner in CHAMPS in order to maintain an accurate roster, as well as to ensure that beneficiaries have the correct PET and benefit plans assigned for correct payments.

Hospitals must submit facility admissions via CHAMPS for the following beneficiaries:

- Medicaid deductible beneficiaries (regardless of the length of stay).
- Medicaid eligible beneficiaries if their stay is expected to be 30 days or greater.
- Private Pay admission if applying for Medicaid (regardless of length of stay).

Refer to the Beneficiary Eligibility Chapter for additional information about the admission process through CHAMPS.

4.2 AUTHORIZATION OF ADMISSIONS AND SERVICES [CHANGE MADE 7/1/2025]

The following guidelines are intended to assist providers and health plans with common concerns regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require PA. The MDHHS Program Review Division (PRD) must authorize medical/surgical (non-psychiatric) admissions for FFS beneficiaries. If the beneficiary is enrolled in a MHP, the health plan must prior authorize the admission. All psychiatric admissions must be authorized by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Services provided during the inpatient admission may also require PA for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests are not reimbursed unless a health plan's PA process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, for beneficiaries enrolled in a MHP, any non-psychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. For FFS beneficiaries, the non-

psychiatric medical/surgical services should be billed to MDHHS. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the initial mental health assessment will be the responsibility of the health plan. The PIHP/CMHSP must be contacted for authorization of subsequent psychiatric services and is then responsible for payment for the psychiatric services.

- If a beneficiary is admitted to an acute care inpatient hospital facility and the enrollment status changes during the admission (e.g., a FFS beneficiary enrolls in a MHP), the payer at the time of admission is responsible for payment for all services provided until the date of discharge. Services provided after discharge are the responsibility of the new payer. The discharge planning process should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one acute care inpatient hospital to another acute care inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the acute care inpatient hospital setting to a non-acute care inpatient hospital setting.
- If a beneficiary is transferred from an acute care inpatient hospital to an inpatient rehabilitation hospital or a long term acute care hospital (LTACH), this constitutes a discharge. The new payer assumes payment responsibility upon admission to the inpatient rehabilitation hospital or LTACH.

Change in Setting	Payer Responsibility in New Setting
Acute care inpatient hospital to another acute care inpatient hospital	Payer at admission remains the responsible party while the beneficiary is in the acute care inpatient hospital level setting. **Exception:** CSHCS enrollment.
Acute care inpatient hospital to inpatient rehabilitation hospital or LTACH	New payer is responsible party upon admission to the inpatient rehabilitation hospital or LTACH.
Inpatient rehabilitation hospital or LTACH to acute care inpatient hospital	New payer is responsible party upon admission to the acute care inpatient hospital.

The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted on 9-15, enrolled in a health plan on 10-1, and discharged from the hospital on 10-5. The health plan is not responsible for services until 10-5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge, such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.

Health Plan to Health Plan with Transfer to Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the beneficiary develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP/CMHSP. During the admission, the patient requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

(text deleted 7/1/2025)

Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)

4.3 Ongoing Services and Extended Treatment Plans

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new responsible party. Enrollment in a health plan always triggers an authorization process through the new or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize, as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

The following are examples of situations that may occur while providing care to an eligible beneficiary:

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, MDHHS authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery, as the health plan is now the payer, not FFS. MDHHS authorization would be void.
Voluntary Health Plan Change During a Course of Treatment	A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care, and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. Providers cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

4.4 Durable Medical Equipment [Title Revised & Change Made 7/1/2025]

MDHHS policy directs providers to bill the date of delivery for durable medical **(text revised 7/1/2025)** equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the comments/remarks section. This is especially important when a person changes from FFS to a health plan.

SECTION 5 - PROVIDER PREVENTABLE CONDITIONS (PPCS)

5.1 REPORTING AND NON-PAYMENT FOR PROVIDER PREVENTABLE CONDITIONS (PPCS)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by MDHHS for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

5.2 HEALTH CARE ACQUIRED CONDITIONS (HCAC) – INPATIENT HOSPITAL

MDHHS follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim.

POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses.

Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

5.3 OTHER PROVIDER PREVENTABLE CONDITIONS (OPPCS) – OUTPATIENT

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs.

Conditions currently identified by CMS include:

- wrong surgical or other invasive procedure performed on a patient;
- surgical or other invasive surgery performed on the wrong body part; and
- surgical or other invasive procedure performed on the wrong patient.

5.4 NON-PAYMENT AND REPORTING REQUIREMENTS PROVIDER PREVENTABLE CONDITIONS (PPCS) – INPATIENT

MDHHS follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported.

If covered services/procedures are also provided during the same stay, MDHHS follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. MDHHS follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

5.5 Non-Payment and Reporting Requirements Other Provider Preventable Conditions (OPPCs) – Outpatient

Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).

SECTION 6 – HOSPITAL CLAIM COMPLETION – INPATIENT

Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing hospital claims. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

The following references unique billing requirements for completing inpatient claims**.**

6.1 ACCOMMODATIONS

Hospitals must use the appropriate revenue code that best indicates the type of room the beneficiary occupied.

Personal comfort and convenience items (e.g., telephone, television) are not covered by Medicaid and cannot be used to offset the beneficiary-pay amount. Charges for these services must not be included on the claim.

6.1.A. INTENSIVE CARE

Refer to the NUBC Manual for the specific cost center for a specific type of intensive care unit and the definitions and report the most appropriate revenue code. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

6.2 SPECIAL BILLING

6.2.A. GENERAL INFORMATION

Coding	All unlisted or not otherwise classified (NOC) codes require an explanation of the service/item provided. The explanation may be entered in the Remarks Section or may be provided as a claim attachment. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDHHS does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement. **Claims will be rejected for inappropriate recoding even if PA was issued by MDHHS.**
Diagnosis Coding	Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits. If a code requires additional digits, the claim will reject.

Prior Authorization	For elective services requiring PA, authorization must be obtained prior to providing services. Do not submit the letter with your claim; however, you must report the PA number appropriately (form locator, segment) when billing for the PA services.
National Uniform Billing Committee Manual	This manual may be purchased from the American Hospital Association, National Uniform Billing Committee. (Refer to the Directory Appendix for contact information.) Data elements used in the paper UB-04 are also used in the electronic claim standard required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Refer to the Directory Appendix for contact information.)

6.2.B. Changes in Facility Ownership During a Beneficiary's Inpatient Stay

When a change in facility ownership occurs during a beneficiary's inpatient stay, the owner on the date of admission should submit a claim for all inpatient hospital services for the beneficiary regardless of when the admission began and ended. The National Provider Identifier (NPI) of the hospital facility on the date of admission is the applicable billing NPI for claims to Medicaid.

Claims must include necessary information for Medicaid to compute the payment amount, whether or not some of the services occurred during a period when a different party legally owned the hospital. Payments are not prorated between the buyer and seller.

6.2.C. Special Circumstances for Hospital Readmissions and Transfers

Neonatal Intensive Care Unit (NICU) Return Transfers	Stabilized infants from NICUs may transfer back to the hospital from which the infant was originally transferred. Transfers may be authorized, with parental consent, to another community hospital when the original facility is at capacity or not closely located to the patient's home. A Prior Authorization Certification Evaluation Review (PACER) must be authorized through the MDHHS PRD for elective transfers between hospitals. NICU return transfer requests for continued medical care at a lower acuity hospital will be authorized if a neonatologist provides a written order to transfer to the originating or community hospital for bonding, teaching, and growth. Existing hospital and ambulance transfer reimbursement methodology will be utilized when prior authorization is granted.
Readmissions (DRG Hospitals Only)	Under the fee for service DRG reimbursement system, payment is intended to include all services required to treat the beneficiary. The DRG system is designed to carefully monitor and control readmissions. MDHHS defines a readmission as any admission within 15 days of a previous discharge, whether the readmission is to the same or a different hospital. **Example:** If a beneficiary is discharged on November 13, 2009 and is readmitted before November 28, 2009, this is considered a readmission within 15 days. (Count the day of the original discharge and the day of readmission.) If the beneficiary is discharged on November 13, 2009 and is readmitted on November 28, 2009, this is considered a new admission. (The beneficiary is discharged and is readmitted after 15 days have elapsed.) MDHHS PRD reviews hospital claims on a pre-payment basis and on a post-payment basis to determine the appropriateness of readmissions. If MDHHS determines that a readmission within 15 days was inappropriate, monies are recovered from the hospital.

Readmission within 15 days to the Same Hospital (Unrelated Readmission)	If a beneficiary is readmitted to the same hospital within 15 days for a condition(s) unrelated to the previous admission (e.g., gall bladder removal, injuries due to a car accident), Medicaid considers the case a new admission for payment purposes. ▪ The provider must submit two separate claims to assure appropriate processing. ▪ A claim for the first admission must be submitted and paid prior to submission of the readmission claim. ▪ When completing the second (readmission) claim, the hospital must indicate the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.
Readmission within 15 days to the Same Hospital (Related Admission)	If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim. No PACER number is issued for continuation of care. ▪ Revenue code 0180 is used for the days the beneficiary was not in the hospital. ▪ Enter the number of leave days in the service units field. ▪ Leave the rate and total charges blank. ▪ Include the leave day units in the total units field. ▪ Report Occurrence Span Code 74 with "from" and "through" dates of the leave of absence. ▪ If the original admission has been submitted and paid, a replacement claim must be submitted that contains the combined services for the original admission and the readmission.
Readmission within 15 days to a Different Hospital	Enter the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.
Transfers	Authorization for a transfer is granted only if the transfer is medically necessary and the care/treatment is not available at the transferring hospital. Transfer for convenience is not considered. Authorization should be obtained by the next business day for emergent/urgent transfers. ▪ The receiving hospital enters the PACER number of the approved transfer in the treatment authorization field. ▪ Submission of documentation with the claim is not required when billing transfers.

6.2.D. Fiscal Year-End/Interim Billing (DRG Hospitals Only)

Hospitals reimbursed under the DRG system generally cannot submit interim billings. The hospital must wait until the beneficiary is discharged and then bill for all services on one claim. However, if a beneficiary has been continuously hospitalized for at least one year and is expected to remain hospitalized for at least another six months, the hospital may submit a claim as if the beneficiary has been discharged. At least every three months thereafter, the hospital should submit a replacement claim which alters the date

of discharge and increases the charges. The Remarks Section of the replacement claim must indicate the reason for filing (i.e., interim billing due to extended length of stay).

6.2.E. Gender/Diagnosis Conflict

Medical services are available to beneficiaries based on medical need regardless of how the beneficiary identifies or expresses for gender. Claims and encounters for some services may be inadvertently denied or rejected due to sex-specific editing unless billed properly.

Report institutional claims and encounters for services that may pose a gender/diagnosis/procedure conflict or may be subject to related mismatch edits with claim level condition code 45 Ambiguous gender category.

Fee-for-Service claims may also be reported with a diagnosis code from the gender identity category (F64), and these will suspend for review and payment.

6.2.F. Hysterectomy

To encourage electronic billing and reduce administrative burden, MDHHS allows for submission of the Acknowledgement of Receipt of Hysterectomy Information form (MSA-2218) via fax. (Refer to the Forms Appendix for additional information.) This form must be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. Submitting this form via fax can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

The provider who obtains the required acknowledgement and completes the MSA-2218 may fax the completed form, along with a cover sheet, to the Medicaid Payments Division. The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted without attachments.

The procedure for approval of the acknowledgement form is:

- Complete a cover sheet (typed or printed) which must include beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax claims.
- Wait for a response. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information for Medicaid staff to contact the provider. Resend the information if necessary.

- All providers may then submit claims (either electronic or hard copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Acknowledgement on File."
- When hysterectomy claims are received with this information in the Remarks, acknowledgement form edit requirements are forced if the submitted invoice matches the acknowledgement form on file.

This process is an option. Providers may continue to attach a copy of the acknowledgement form to the claim without going through this pre-approval process. If a paper copy of the MSA-2218 is attached with the claim, indicate "submitted attachment" in the Remarks Section.

When billing for a hysterectomy performed during a beneficiary's period of retroactive eligibility, indicate in the Remarks section "MSA-2218 not completed. Not eligible on date of service." Also indicate the beneficiary was informed prior to the hysterectomy that the service would render them incapable of reproducing.

When billing for a beneficiary that was sterile prior to the hysterectomy, the Acknowledgement of Receipt of Hysterectomy Information form is not required. The Remarks field of the claim must indicate "Beneficiary sterile prior to hysterectomy" along with the cause/procedure that rendered them sterile.

6.2.G. Loss/Gain Medicaid Eligibility

Under the DRG system, hospitals must wait until a beneficiary is discharged and then bill all services on one claim. Hospitals generally cannot split-bill DRG claims. If a beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid eligible days as follows:

- The "from" and "through" dates must reflect only the days of Medicaid eligibility.
- The patient status code must reflect the actual status of the entire admission.
- The Remarks section must indicate that the beneficiary was Medicaid eligible for a portion of the hospital stay.
- The admission date must reflect the date the order to admit the beneficiary was written.

When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.

6.2.H. Medicare

For Medicare Parts A and B/Medicaid claims, Medicaid only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance, deductible) or the Medicaid DRG, whichever is less. Medicaid payment does not include capital and direct medical education.

Due to the nature of DRG calculations, the following instructions must be used when completing an inpatient hospital claim:

- All Medicare and other insurance payment information should be indicated on the claim which contains the Patient Status code that indicates the beneficiary has been discharged from the facility. If the inpatient service requires two claims, payment information (e.g., total other insurance payment, Medicare coinsurance and deductible) must be included on the claim for the last date of service for the inpatient stay. Interim claims should not reflect a payment.
- Medicare Part A and Part B charges must be combined on one claim.
- When a beneficiary has Medicare Part B only, this must be reflected in the Remarks section of the claim. Additionally, the claim must reflect the 20 percent amount due from Medicaid. The Medicare Part A and Part B payment is the 80 percent of the allowable charges covered by Medicare for Part B services.

For Medicaid reimbursement, the amount billed for services does not equal the sum of the coinsurance and deductible items. It must be calculated as the gross hospital charges **minus** all Medicare payments, **minus** other insurance payments, and **minus** any patient-pay and/or copayment amount. If a claim is submitted with the amount billed equal to zero, other payment greater than or equal to Medicaid's payment, or a negative amount, Medicaid does not make a payment. If there is a balance to be billed to Medicaid, the hospital may bill Medicaid for covered services only.

For Medicare Part B/Medicaid claims where Medicare Part A is exhausted, Medicaid pays up to the beneficiary's financial obligation to pay or the Medicaid DRG (or per diem rate) less the total amount paid by all other payers, whichever is less. Medicaid reimbursement includes capital and direct medical education (made at final settlement).

Medicare Part A Exhausted Prior to Stay	▪ Report Type of Bill 0111 and enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ Medicare Part B payment must be reflected on the claim.
Medicare Part A Exhausted During Stay	▪ Report Type of Bill 0111 and enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report value code A2 (coinsurance).

Medicare Part A Becomes Effective During Stay	▪ Enter occurrence code A2 and the date when Medicare Part A becomes effective. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report amount applied to coinsurance, copay or deductible [OI and Medicare (Inpatient, Outpatient, LTC, Home Health, Hospice)]. ➢ For DOS prior to July 1, 2007 – electronic/paper claims: Value Code A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount ➢ For DOS on/after July 1, 2007: ♦ Electronic claims: use CAS segments only ♦ Paper claims: use only Value Codes (A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount)

6.2.I. Multi-Page Claim (Paper Claim)

Inpatient hospitals can report charges on multiple pages when services exceed more than 22 lines. MDHHS is unable to accept multiple-page paper claims for all institutional providers (Inpatient, Outpatient, LTC, Home Health, Hospice). Providers are encouraged to bill electronically whenever possible for faster payment.

6.2.I.1. Initial Claim

Refer to the NUBC Manual for reporting multiple pages (on line 23) and total charges.

6.2.I.2. Claim Replacement

Refer to the NUBC Manual for submitting a claim replacement TOB. Enter the 18-digit Transaction Control Number (TCN) of the last approved claim being replaced in the appropriate FL or loop/segment if billing electronically.

When information which affects the entire claim needs to be corrected (i.e., diagnosis coding, other insurance payments, etc.), replace only the claim with an approved dollar amount greater than zero. The DRG assignment and/or amount approved may be changed.

6.2.J. Newborn Eligibility

All newborn services must be billed under the newborn's ID number. The hospital must not bill under the mother's ID number. If an ID number has not been assigned prior to or at the time of delivery, the State's Electronic Birth Certificate (EBC) system is the preferred method of adding Medicaid coverage and assigning a MHP to newborns with mothers who are Medicaid beneficiaries. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. (Refer to the Forms Appendix for additional information.) If the MSA-2565-C form is used, the local MDHHS office will open the

newborn's MA case and return the form to the provider with the necessary billing information. Providers must not bill until the eligibility response shows the newborn's ID number, date of birth, and the sex. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information regarding verifying beneficiary eligibility. Refer to the Hospital Chapter of this manual for PACER requirements for newborns.)

If the mother is enrolled with a MHP at the time of birth, all newborn charges must be billed to the MHP.

6.2.K. Inpatient Hospital Claim Requirements for Newborns

Providers are required to adhere to NUBC guidelines for reporting newborn priority (type of) admission or visit, newborn birth weight, and cesarean sections/inductions related to gestational age. Birth weight should be reported as a whole number. For example, if the birth weight is 2764.5 grams, then the NUBC value code should be reported as "2765". Claims that fail to report newborn priority (type of) admission or visit and newborn birth weight will be denied.

6.2.L. Patient-Pay Amount

- Value code D3 followed by the dollar amount is used to reflect the patient-pay amount.
- The facility must submit a claim to Medicaid even though the patient-pay amount is sufficient to cover the cost of the entire admission.
- The facility must not bill the beneficiary for any balance between the facility charges and the patient-pay amount.
- If a beneficiary is discharged and/or transferred to another facility within the same calendar month, the first facility collects the patient-pay amount. If a patient-pay amount was deducted from the second admission in error, a claim replacement must be submitted.
- When an admission spans two or more months, the nursing facility must collect the patient-pay amount for each month the beneficiary is in the nursing facility (for PETs LTC-NFAC and LTC-CMCF) and in hospice (PET HOS-NFAC).
- When an admission spans two or more months, the facility only collects one spend-down amount for the entire hospital admission.

6.2.M. Drugs and Therapeutics Carved Out of Hospital DRG Payment

Effective for dates of service on or after October 1, 2023, separate reimbursement is available for certain drugs and therapeutics that are medically necessary in the inpatient hospital setting. Drugs and therapeutics that are carved out of the diagnosis related group (DRG) will be published and maintained on the MDHHS billing and reimbursement webpage for Inpatient Hospitals. (Refer to the Directory Appendix for website information.)

Claims for drugs and therapeutics that are carved out of DRG are paid through the Fee For Service (FFS) benefit for beneficiaries in Managed Care and FFS. There is no copayment responsibility to the beneficiary for drugs and therapeutics when administered in the inpatient hospital setting. These drugs and therapeutics may be covered as either professional claims or pharmacy claims. If a drug or therapeutic does not have a specific Healthcare Common Procedure Coding System (HCPCS) code established and is identified using an unlisted or NOC code, then it must be submitted on a pharmacy claim to be considered for reimbursement. Pharmacies and billing providers must ensure that claims are not duplicated. PA may be required.

6.3 Clinical Trials

All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial. Claims must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)

6.3.A. Reporting Covered Services

Submit claims for services on the CMS UB04/837I institutional claim format as follows:

- Report Z00.6 in the primary or secondary position.
- Report condition code 30 whether all services are related to the clinical trial or not.
- For paper/direct data entry, report the clinical trial number in Field Locators (FL) 39-41 for value code D4.
- For electronic claim 837I, report the clinical trial number in Loop 2300 REF02 (REF01=P4).

6.3.B. Reporting Non-Covered Services

Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim using Type of Bill (TOB) 0110 (no-pay claim). The non-covered claim must be billed with the same Statement Covers Period (From and Through date) as the payable TOB 011X submitted for the same stay as the covered services related to the clinical trial. Include the clinical trial identifiers listed above on the no-pay claim. Claims submitted with TOB 0110 will result in a denial.

Refer to the Billing & Reimbursement for Professionals and the Practitioner chapters for additional information.

6.4 Rehabilitation Units

For Medicare recognized distinct part rehabilitation units, MDHHS recommends that providers report the appropriate taxonomy code on all claims submitted, either electronically or by paper, to ensure proper adjudication. Within the ASC X12 837 5010 institutional format, report the valid taxonomy code in provider loop 2000A (billing/pay-to-provider taxonomy code). For paper claims, use the Code-Code field within the UB-04 claim form. The PACER number must be entered on the claim in the treatment authorization field.

6.5 Sterilization

For coverage policy information, refer to the Hospital Chapter of this manual. Refer to the Forms Appendix of this manual for a copy of the Consent for Sterilization (MSA-1959/HHS-687), including completion instructions. If any field on the form is improperly completed, the claim is rejected.

The procedure for completion of the MSA-1959/HHS-687 form is:

- Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed MSA-1959/HHS-687. Do not fax claims.
- Wait for a response. When notified that the MSA-1959/HHS-687 has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information needed for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or paper copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Consent on File."
- The information on the sterilization claim must match the information on the MSA-1959/HHS-687. If it does not, the claim is rejected.

This process is optional. Copies of the MSA-1959/HHS-687 may be attached to a claim without going through the pre-approval process. If choosing to include a paper copy of the MSA-1959/HHS-687, indicate "submitted attachment" in the Remarks section.

6.6 Telemedicine

To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine facility fee code and modifier. Refer to the Telemedicine Chapter for additional information. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

6.7 Transplants

Heart, liver, lung, simultaneous pancreas/kidney, kidney and pancreas transplants are reimbursed at the hospital's Medicaid cost-to-charge ratio.

- Organ acquisition costs are reimbursed at 100% of charges when billed using either revenue code 0811 or 0812. This applies to heart, liver, lung, simultaneous pancreas/kidney, kidney, or pancreas transplants.
- The letter of authorization for the transplant from the Office of Medical Affairs (OMA) or MHP must be attached to all applicable transplant claims, otherwise payment is denied.
- Indicate "PA letter submitted" in the Remarks section of the submitted claim.
- For other transplant services not described by a specific DRG, identify in the Remarks Section the type of transplant that has been performed (i.e., small bowel transplant).
- If the donor and beneficiary are both Medicaid eligible, the services must be billed under each beneficiary's respective ID Number. If only the beneficiary is Medicaid eligible, bill services for both donor and beneficiary under the Medicaid beneficiary's ID Number.

All other insurance resources must be exhausted before Medicaid is billed. If Medicare eligibility is denied, the denial notice must be submitted with the claim.

SECTION 7 – HOSPITAL CLAIM COMPLETION – OUTPATIENT

Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Outpatient Hospital claims. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

7.1 OPPS/AMBULATORY PAYMENT CLASSIFICATION

7.1.A. PACKAGED/BUNDLED SERVICES

MDHHS follows Medicare guidelines for packaged/bundled service costs. Services having a status indicator (SI) of "N" are considered packaged/bundled into other services. The costs of these services are allocated to the APC but are not paid separately. Providers must report all HCPCS/CPT codes and charges for all services provided on a claim whether payment for the service(s) is made separately or is packaged in order for the claim to pay correctly. Charges related to the packaged services are used for the outlier calculation.

Packaged services revenue codes, when billed under OPPS, do not require a HCPCS code. Any other revenue codes billable on an outpatient hospital claim must contain the HCPCS code to assure payment under OPPS.

7.1.B. PAYMENT STATUS INDICATORS

For categories covered differently than Medicare under the MDHHS OPPS, refer to the MDHHS OPPS Wraparound Code List posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Medicare assigns a payment status indicator (SI) to every HCPCS code and identifies whether the service described (by the HCPCS code) is paid under OPPS, and whether payment is made separately or packaged. The SI may also provide additional information about how the code is paid under OPPS or under another payment system or fee schedule. A list of Medicare SIs with their definitions is in Medicare's Addendum D. Medicare's Addendum B shows the status indicator for each HCPCS code. (The Addendums are available on the CMS website. Refer to the Directory Appendix for website information.)

7.1.C. TYPE OF BILL

The following Type of Bill (TOB) are accepted for outpatient claims under the MDHHS OPPS: 13x, 14x, 34x, 72x, 74x, 75x or 85x.

7.1.D. REPORTING CPT/HCPCS CODES

The OPPS payment calculations are dependent on CPT/HCPCS procedure codes and modifiers reported at the claim line level. Providers are advised to ensure the accuracy of procedure codes, the OPPS modifiers, and the appropriateness of the revenue codes.

MDHHS uses the Medicare HCPCS/Revenue Code Chart as a guide for how hospitals report services.

7.1.E. Date of Service

OPPS requires a claim line date of service for each service billed. If a claim line date of service is not entered for each HCPCS code reported or, if the line item dates of service reported are outside of the "statement covers" period ("from" and "through" dates), the claim will be returned to the provider.

If the claim spans more than one calendar day, the Outpatient Code Editor (OCE) will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day. Per Federal Regulations, the MDHHS OPPS uses Medicaid NCCI and MUE values for OPH claims processing. The Medicaid NCCI and MUE values are reviewed with the quarterly file updates.

All services for a single outpatient encounter must be reported on one claim, except for Medicare's allowable repetitively billed services and hospital-owned ambulance services. MDHHS aligns closely with Medicare's guidelines for monthly repetitive billing.

7.1.F. Late Charges

Late charges do not apply for outpatient hospital (Type of Bill 135). A claim replacement must be submitted to report correct charges. (Refer to the Replacement, Void/Cancel Claims and Refund of Payment Section of this chapter for additional information.)

7.1.G. Repetitive Services Billing

MDHHS follows Medicare's Repetitive Services billing for Medicaid covered services when billed appropriately.

7.2 Abortion

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest. The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions. Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections.

(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550.)

7.3 AMBULANCE

Claims for hospital-owned ambulance services must be billed using the current 837I or UB paper claim format and Medicare claim completion instructions except as noted below. Hospital-owned ambulance Medicaid-enrolled providers submitting Emergency Ambulance Transport claims may report the National Provider Identifier (NPI) of the attending physician, however, completion of this field is not required.

For coverage policy information, refer to the Ambulance Chapter of this manual. Additional information related to appropriate coverage support codes and reimbursement is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.3.A. BILLING INSTRUCTIONS FOR HOSPITAL-OWNED AMBULANCES

- The appropriate NUBC Ambulance revenue code with the appropriate MDHHS covered ambulance CPT/HCPCS procedure code(s) must be reported for each ambulance trip on the individual service line(s).
- For proper claim payment, the appropriate taxonomy code must be reported along with the NPI to designate ambulance, land, air, or by water. (Report the valid taxonomy code in loop 2000A of the ASC X12 837 5010 electronic format or the Code-Code field within the UB-04 paper claim form.)
- A revenue code, HCPCS code(s) and a modifier(s) are required for billing ambulance services and mileage.
- The claim line date of service must be reported for each revenue code line in the Date of Service field for each revenue code used.
- A one-way ambulance trip is reported on two separate consecutive revenue code lines: one line represents the ambulance service provided, and one line represents the mileage.
- Units must be reported in the Service Units field. The number of units reported for the revenue line reflecting each ambulance trip should always equal "1".
- The appropriate origin and destination modifier(s) must be included on the service line when billing for mileage.

Origin and Destination Modifiers	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non hospital-based dialysis facility

Origin and Destination Modifiers	Description
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

7.3.B. Multiple Transports Per Beneficiary

When a beneficiary requires more than one ambulance transport on the same date of service, providers must report:

- the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and
- the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles.

If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transports subsection of the Ambulance Chapter of this manual.

7.3.C. Multiple Patient Transport

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported.

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.

7.3.D. Mileage

When billing a mileage code for trips totaling:

- Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles).
- 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy.

NOTE: Because the National Uniform Billing Committee (NUBC) UB-04 paper claim form cannot accommodate fractional billing, hard copy ambulance billers submitting the UB-04 should report mileage units rounded up to the nearest whole mile.

7.3.E. Wait Time

When billing for wait time (if more than 30 minutes of waiting time occurs), report the procedure code and enter the appropriate number of time units in the Service Units field. Bill one time unit for each 30 minutes of wait time over and above the first 30 minutes.

If more than four hours of waiting time is required, providers must request individual consideration and provide documentation. Documentation is required when billing wait time regarding the circumstances, noting under Remarks or submitted as an attachment with the claim.

7.3.F. ZIP Code

MDHHS does not require reporting the ZIP code of the geographic location for pricing.

7.4 Anesthesia

MDHHS aligns as closely as possible with Medicare's anesthesia billing guidelines. Under OPPS, anesthesia services are packaged services, with items and services considered an integral part of another service being included in the APC payment for that integral part. Anesthesia, routine supplies, recovery room, and most drugs are considered an integral part of a surgical procedure; therefore, payment of these items is packaged into the APC payment for the surgical procedure.

Providers must bill all packaged items and services appropriately.

CRNA, AA, and physician professional charges should not be included in the outpatient hospital bill. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information related to billing professional services.)

7.5 Apheresis

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for Apheresis services.

7.6 Beneficiary Education

7.6.A. Childbirth Education

Childbirth education services must be billed upon completion of the course.

- Report the quantity as "1".
- Enter the last date the beneficiary was seen for childbirth education in "statement covers period".
- The "from" and "through" dates must be the same.

7.6.B. Kidney Disease Education (KDE)

MDHHS follows Medicare's billing and reimbursement requirements for covered Kidney Disease Education (KDE) services.

- Bill the appropriate NUBC Revenue Code.
- Bill the appropriate CPT/HCPCS code for KDE.
- Bill the appropriate diagnosis code.

7.7 Blood and Products

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing blood or blood products.

7.7.A. Transfusion Services

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for transfusion services.

7.7.B. Unused Blood

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for blood bank unused blood, processing and storage costs. The OPPS provider must not bill the beneficiary for these storage costs.

7.8 Clinic Services

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing Hospital Clinic services rendered in a clinic setting (that is part of the licensed, Medicaid enrolled hospital) and that satisfy Medicare requirements for provider-based status.

Clinic services rendered in the outpatient hospital include non-emergency outpatient services that are provided to ambulatory beneficiaries.

7.9 Clinical Trials

All outpatient hospital facility claims for routine patient costs associated with participation in a qualified clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/837I institutional claim format. (Refer to the Hospital Claim Completion – Inpatient section, Clinical Trials subsection for additional information.) In addition, outpatient hospital facility claims must include:

- A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210).
- Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim.
- Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1.
  - HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study.
  - HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.

Report non-covered services/charges with the appropriate modifier and a token charge ($1) for a 'no cost' item in the covered charge field.

Refer to the Billing & Reimbursement for Professionals and the Practitioner chapters for additional information.

7.10 Cosmetic Surgery

A copy of the authorization letter that was sent to the attending physician from the OMA or MHP must be submitted with the claim.

Indicate "PA letter submitted" in the Remarks section.

7.11 Dental Services

PA is not required for the outpatient hospital setting for FFS beneficiaries. However, PA may be required for MHP enrollees.

The hospital must bill the appropriate supporting HCPCS code and the appropriate revenue code(s).

7.12 Diabetes Self-Management Education (DSME) Training Program

MDHHS follows Medicare's DSME Training (initial and follow-up) billing guidelines as closely as possible. Providers must bill appropriately. All documentation must support that services furnished are provided by a Medicaid enrolled provider who meets Michigan Medicaid DSME program requirements in the appropriate place of service.

Refer to the Hospital Chapter for information regarding DSME program requirements.

7.13 Dialysis (Hemodialysis and Peritoneal)

MDHHS follows Medicare's billing requirements for outpatient and emergency outpatient dialysis services (e.g., the appropriate diagnosis code, patient weight, height, etc.); however, coverage and reimbursement policies differ. Refer to the outpatient portion of the Hospital Chapter of this manual and the MDHHS OPPS Wraparound Code List on the MDHHS website for additional information. (Refer to the Directory Appendix for MDHHS website information.)

7.14 Donor Searches

Charges for donor searches which do not result in an organ acquisition and transplant should be billed as an outpatient service.

- A copy of the PA for the transplant that was sent to the attending physician from the OMA or MHP must be submitted with the claim.
- The appropriate NUBC revenue code should be used with the appropriate CPT/HCPCS procedure code. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)
- Indicate "PA letter submitted" in the Remarks Section.

7.15 Drugs Administered on Premises

Medicaid does not cover the NUBC revenue code for self-administered drugs. Refer to the Revenue Code Requirements Table posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.16 Emergency Department Services

Emergency Department services are to be billed as follows:

EMTALA Screen	The hospital must bill the appropriate NUBC Emergency Department (ED) revenue code with the appropriate ED Evaluation and Management (E&M) code/CPT/HCPCS procedure code when billing the EMTALA screen without follow-up treatment/stabilization services. (Refer to the General Information for Providers and the Emergency Services Only Medicaid chapters for additional information.)
Emergency Department Stabilization/ Emergency Treatment Services	▪ Use the appropriate ED revenue code or combination of codes. ▪ Use the appropriate ED E&M code/CPT/HCPCS code to indicate the level of service provided. ▪ The principle diagnosis code field must reflect the emergency diagnosis resulting from the EMTALA screen. The Admitting Diagnosis Code field should reflect the beneficiary's reason for the emergency room visit. ▪ Hospitals must apply current guidelines designated by the appropriate ED HCPCS code to reasonably relate the intensity of hospital resources to the different E&M levels represented by the codes. **Exception:** The reason the encounter was considered an emergency must be entered in the Remarks Section if the principal diagnosis or the admitting diagnosis does not reflect the definition of an emergency as stated in the federal Balanced Budget Act of 1997 and its regulations. Information in the Remarks Section should include vital signs, medical problems or conditions noted during the ED visit, if an IV was started, and medications administered during the visit. This information must be adequate to confirm the emergent condition. ▪ All outpatient hospital charges for ED services resulting in an inpatient admission must be billed on the inpatient claim. Payment is made through the inpatient reimbursement system (as part of the DRG).
Emergency Department Non-Emergency Treatment Services	Medicaid covers all appropriate hospital charges for ED services, provided that the diagnosis supports procedures billed and/or documentation supports the facility charges. ▪ Hospitals must bill the appropriate NUBC ED revenue code. ▪ Use appropriate ED E&M code/CPT/HCPCS code to indicate level of service provided. ▪ All other services (e.g., laboratory, x-ray, etc.) must be billed consistent with Medicaid's FFS policy. For MHP enrollees, authorization must be obtained prior to provision of non-emergency services in the ED.

7.17 Hyperbaric Oxygen Therapy

MDHHS follows Medicare's Hyperbaric Oxygen Therapy billing guidelines as closely as possible when billed appropriately.

7.18 Hysterectomy

Refer to the Hospital Claim Completion-Inpatient Section of this chapter for information related to hysterectomies.

7.19 Injections

Outpatient hospital providers who bill physician-administered drugs (injectable and non-injectable) separately to Medicaid must report the National Drug Code (NDC) and its supplemental information in addition to the corresponding procedure code (CPT or HCPCS) to assist Medicaid in collecting rebates. Reporting of the NDC is not required for claims that are considered packaged or bundled (Medicare Pay Status = N) under the Outpatient Prospective Payment System (OPPS).

Providers can report decimals if they are part of the NDC supplemental information.

Coverage of a physician-administered drug (except an immunization) is limited to a drug product from a manufacturer who has a signed rebate agreement with the CMS. A current listing of the rebate manufacturers can be found on the CMS website. (Refer to the Directory Appendix for website information.) Providers are required to review the website for any changes. MDHHS will not provide an updated listing of rebate manufacturers.

The NDC information must be reported on all Medicare crossover claims.

Do not recode injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing MDHHS unless MDHHS does not cover that procedure code. When MDHHS covers the procedure code, the same procedure code must be submitted to MDHHS that was submitted to the other payer to ensure proper reimbursement.

When billing a code with a dose-specific description, enter the appropriate quantity. If the dose specified in the code description is exceeded, use modifier 22 and document the actual dosage given in the appropriate segment or form locator.

Up to normal and customary charges can be billed for 340B acquired physician-administered drugs or products when provided in the outpatient hospital setting. Drugs purchased through the 340B program must be indicated on the institutional claim using the MDHHS modifier U6 and CMS modifiers for OPPS 340B acquired drugs.

Invalid or missing NDC information or an NDC by a manufacturer who does not have a signed rebate agreement with CMS will reject at the claim line level.

7.19.A. Electronic Claims

The following NDC information is reported in the appropriate segments of the electronic claim format:

- N4 (2-digit qualifier)
- NDC (11 digits, with 5-4-2 format)
- Unit of Measurement Value (2-digit qualifier)
- NDC Quantity

To report the NDC information in an 837 HIPAA-compliant format with the correct information in the 2410 Loop:

- Repeat the HCPCS code on multiple service line loops, allowing one NDC to be reported within each LIN segment.
- Within the LIN segment, report the 2-digit qualifier along with the 11-digit NDC.
- Within the CTP segment, report the quantity and unit of measurement.
- For the REF segment, the prescription number or Compound Drug Association Number must be reported on each service line to link this service together.

7.19.B. NUBC Claim Format

The National Uniform Billing Committee (NUBC) provides instructions for reporting an NDC and its supplemental information on the NUBC claim format. These instructions can be found on the NUBC website. (Refer to the Directory Appendix for website information.)

To bill a procedure code (HCPCS or CPT) with multiple NDCs:

- Report the first NDC and its supplemental information in the appropriate Form Locator.
- Report the additional NDC and its supplemental information in the Remarks field.

7.19.C. Not Otherwise Classified Code (NOC)

If a nonspecific or not otherwise classified code (NOC) is billed for a drug product, the NDC and its supplemental information must be reported in the appropriate segments of the electronic claim format and the appropriate Form Locator on the UB-04 claim format. The cost of the drug must be reflected in the charges submitted to MDHHS. Enter a quantity of "1."

7.19.D. Drugs and Biological Products Not Covered by Medicaid Health Plans

When multiple OPH or ASC services are provided in conjunction with a carved-out physician-administered drug, claims with the PA number, all services, the appropriate billing codes, and the appropriate National Drug Code (NDC) must be submitted to Medicaid Fee For Service (FFS). Medicaid FFS will process payment of the carved-out

drug service line only. All other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24. Providers are to bill the FFS denied associated services to the beneficiary's health plan.

7.20 Labor and Delivery Room

Labor and delivery room charges must only be billed when labor progresses to delivery.

- Do not report fetal monitoring, a fetal contraction stress test, or a fetal non-stress test in addition to a labor and delivery or false labor room charge when there is no active labor.

False labor charges for a room used by a beneficiary in active labor who does not progress to delivery must be billed using the appropriate NUBC revenue code (i.e., Other Labor Room/Delivery) and the appropriate CPT/HCPCS procedure code.

- A fetal contraction stress test or a fetal non-stress test may be billed in addition to false labor (under the MDHHS OPPS) when medically necessary.
- No other room charges may be billed with the NUBC Revenue Code (Other Labor Room/Delivery) for the same date of service.

Refer to the MDHHS Institutional Billing Resource document (posted on the MDHHS website) for billing updates and additional information. (Refer to the Directory Appendix for website information.)

7.21 Laboratory

Differences in coverage of lab services between MDHHS and Medicare have been identified and are included in the MDHHS OPPS Wraparound Code List available on the MDHHS website.

7.22 Outpatient Observation Services

MDHHS follows Medicare's observation care services coverage, claim submission, and reimbursement policies when billed appropriately.

7.23 Preadmission Diagnostic Services

MDHHS policy/billing guidelines align with billing guidance referenced in the Medicare Claims Processing Manual and the applicable section (i.e., date specific) for "Outpatient Services Treated as Inpatient Services."

MDHHS does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, etc.). (NOTE: This policy does not apply to ambulance providers, freestanding dialysis centers or inpatient rehabilitation hospitals.) MDHHS will use a hospital's tax identification number to align with the CMS definition of "any hospital entity that is wholly owned or wholly operated by" the hospital. Otherwise, MDHHS will align as closely as possible with Medicare policy and guidelines for all beneficiaries.

7.24 Radiation Therapy Services

MDHHS follows Medicare's billing guidelines for repetitive billing on the same claim or separately by date of service. If reporting charges on a single claim, the provider must also report all charges for the radiation services (one episode of care) and supplies for the recurring radiation service on the same claim.

7.25 Rehabilitation Services

MDHHS follows Medicare's billing requirements for Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR).

Hospitals must bill appropriately following Medicare's billing guidelines.

7.26 Self-Care Dialysis Training

Bill self-care dialysis training using the appropriate revenue code and HCPCS/CPT codes. Refer to the MDHHS OPPS Wraparound Code List on the MDHHS website for CPT HCPCS codes. (Refer to the Directory Appendix for MDHHS website information.)

If a beneficiary completes a course:

- Report the appropriate CPT/HCPCS procedure code for dialysis patient training, complete course.
- The quantity should be "1."

If a beneficiary does not complete a course:

- Report each session separately using the appropriate CPT/HCPCS procedure code for dialysis patient training, per session.
- The service date on the claim line must indicate the actual date that the session occurred.
- Report each session using the appropriate CPT/HCPCS procedure code for dialysis patient training, course not completed, per training session.

7.27 Sterilization

Refer to the Hospital Claim Completion-Inpatient Section of this chapter for additional information related to sterilization.

7.28 Telemedicine

To be reimbursed for the originating site facility fee, the hospital must bill the telemedicine facility fee code and modifier. Refer to the Telemedicine Chapter for additional information. Information about telemedicine services is contained in the Telemedicine Chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

7.29 Therapies (Occupational, Physical and Speech-Language)

Therapy services must be reported using the appropriate procedure code and therapy modifier to distinguish the plan of care under which the service is delivered. In addition, when services are habilitative, they must be billed with the appropriate modifier that represents the nature of the therapy performed. Maintenance therapy services should also include the MDHHS designated maintenance modifier. Therapy services submitted without these modifiers may be denied.

Modifier	Description	Special Instructions
GN	Service delivered under an outpatient speech-language pathology plan of care.	Identifies services provided under a speech therapy treatment plan.
GO	Service delivered under an outpatient occupational therapy plan of care.	Identifies services provided under an occupational therapy treatment plan.
GP	Service delivered under an outpatient physical therapy plan of care.	Identifies services provided under a physical therapy treatment plan.
96	Habilitative Service	Used to identify therapy services habilitative in nature.
97	Rehabilitative Service	Used to identify therapy services rehabilitative in nature.
TS	Follow-up Service	Used to identify therapy services as maintenance related.

Outpatient hospital facility providers must also report the appropriate therapy assistant modifier when services are furnished in whole or in part by a physical therapy or occupational therapy assistant. In cases where both a physical or occupational therapist and a physical or occupational therapist assistant (PTA/OTA) provide a portion of the same untimed service or 15-minute timed unit of service, Medicaid will utilize Medicare's de minimis standard in determining if the service/unit is considered to be furnished in whole or in part by a PTA or OTA.

For MHP enrollees, the provider should check with the MHP for PA requirements. Refer to the Therapy Services chapter for additional information related to therapies.

Occupational Therapy (OT)	▪ Refer to the Therapy Services chapter for information regarding OT benefit maximums and PA requirements. For MHP enrollees, the provider should check with the MHP for PA requirements. ▪ OT must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. ▪ Therapy must be provided by the evaluating discipline. Evaluation or reevaluation may be billed with other OT services on the same day. Therapy must be provided by the evaluating discipline. ▪ Co-treatment therapy can be billed under one therapist or can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units billed must not exceed the total time the beneficiary received co-treatment services. ▪ The fee for OT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to OT.
Physical Therapy (PT)	▪ Refer to the Therapy Services chapter for information regarding PT benefit maximums and PA requirements. For MHP enrollees, the provider should check with the MHP for PA requirements. ▪ For PT services, use a revenue code with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. The fee screen for PT includes all services. ▪ The fee for PT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to PT. ▪ Evaluation or re-evaluation may be billed with other PT services on the same day. Therapy must be provided by the evaluating discipline. ▪ Serial casting must be billed under the manual therapy technique procedure code. ▪ Co-treatment therapy can be billed under one therapist or can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units billed must not exceed the total time the beneficiary received co-treatment services.

Speech-Language Therapy (ST)	▪ Refer to the Therapy Services chapter for information regarding ST benefit maximums and PA requirements. For MHP enrollees, the provider should check with the MHP for PA requirements. ▪ Speech therapy must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. ▪ Evaluation or re-evaluation may be billed with other speech pathology services on the same day. Therapy must be provided by the evaluating discipline. ▪ The fee for speech-language therapy includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to speech therapy. ▪ If co-treatment therapy includes services that are reported as an untimed session, they may be billed by the SLP as one unit. The therapy session must be at least 38 minutes in length to bill both speech therapy and another discipline.

7.30 Ultrasonography

Claims for diagnostic ultrasound procedures which are performed more than once require documentation of medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure (e.g., multiple gestation, breach presentation, pre-term labor, etc.). Claims are rejected if the documentation does not support the medical necessity for the repeat diagnostic procedure.

7.31 Weight Reduction

A copy of the letter of authorization for the weight reduction that was sent to the attending physician from the OMA must be submitted with the claim.

Indicate "PA letter submitted" in the Remarks Section.

SECTION 8 – NURSING FACILITY CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing nursing facility claims.

Only one calendar month is to be billed on a nursing facility claim.

For Room and Board, the service line from and to date (if reported) must match that of the claim header from and through dates and be reflected in the units billed. The room and board revenue code billed must be for the appropriate room type. Both Revenue Codes 0110 and 0120 must not be billed on two separate claims for the same beneficiary and same/overlapping service dates. These claims will be denied or recouped if paid incorrectly.

8.1 SPLIT BILLING – STATEMENT COVERS PERIOD

The Statement Covers Period on the claim is used for reporting the beginning and ending dates of service for the entire period reflected on the claim. In instances where the facility is split billing the month, the From and Through dates must be for only the period reflected on the claim.

Example: Facility is split billing April. On the first claim, the From date would be 040105 and the Through date would be 041505 for 15 days. The second claim From date would be 041605 and the Through date would be 043005 for 15 days.

If a patient-pay amount is involved on both claims, the facility is reminded that the first claim must be paid before submitting the second claim. Refer to the Patient-Pay portion of this section for additional information.

Failure to follow the above claim completion instructions will result in unnecessary suspending of claims and delays in processing.

8.2 PATIENT-PAY AMOUNT

8.2.A. ONE FACILITY – TWO CLAIMS IN ONE MONTH

When a nursing facility must submit two claims within the same month for the same beneficiary who has a patient-pay amount, the following instructions must be followed:

- The claim for the first service dates in the month must be submitted before the claim for the remainder of the month, even if the patient-pay amount is equal to or greater than the amount billed; and

- The first claim must be paid before submitting the second claim. If the first claim is suspended or rejected, and the second claim is submitted and paid, the whole patient-pay amount is deducted incorrectly from the net amount due on the second claim, even if all or a portion of the patient-pay amount was to have been deducted from the first claim. A replacement claim is required for the second claim to correct the underpayment after both claims are paid.

Facilities must report the total patient-pay amount on the first claim. If there is any remaining patient-pay amount, the amount must be reported on the second claim. The total patient-pay amount is not to be reported on both the first and second claims.

8.2.B. Two Facilities – Two Claims in One Month

If a beneficiary with a patient-pay amount resides in more than one Medicaid-certified facility in the same month:

- The first facility must submit a claim:
  - For the days the beneficiary resided in the facility (even if the amount billed is zero because the amount due is covered by the patient-pay amount);
  - To be paid for any amount due that is more than the patient-pay amount; and
  - For the second facility to receive the correct payment.
- If the first claim has not been submitted or is suspended or rejected, and the second facility submits its claim, the whole patient-pay amount is deducted from the amount due on the second claim. The second facility needs to void their claim in order for the first facility to bill their claim so the PPA may be applicable. Once that is complete, the second facility can rebill a new claim to receive its proper payment.

  Note: Nursing facilities must not contact the beneficiary's Michigan Department of Health and Human Services (MDHHS) case worker as the case worker cannot change the patient-pay amount in these situations nor is it warranted. Facilities must bill as outlined above.

8.2.C. Offset to Patient-Pay Amount for Noncovered Services

Notes:

- Pre-Eligibility Medical Expenses: This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.)
- Private Insurance Premiums: Premiums for private insurance cannot be reported on a claim to Medicaid as an offset to the patient-pay amount. The cost of insurance premiums must be handled by the beneficiary's local MDHHS office worker. The MDHHS worker will determine if the cost of the insurance is an allowable expense/offset. Any cost of a premium is not permissible on a claim submitted to Medicaid.

Claims containing an offset to the patient-pay amount cannot be split-billed. The facility must submit one claim for the particular month of service. The offset must be reported for the month that the services were provided.

The offset for the noncovered service must be reported on the claim using the appropriate value code and FL 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through CHAMPS.

The dollar amount of Value Code D3 minus Estimated Responsibility Patient (patient-pay amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would indicate $200 as an offset with D3 as zero. The third month claim would indicate $100 as an offset with D3 as $100.

8.2.C.1. Claim Documentation Requirements When Offsetting the Patient-Pay Amount

Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

Documentation Requirements	The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service. The nursing facility must upload the documentation to the Document Management Portal (DMP). The nursing facility is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.) **Note:** The nursing facility must report in the Note section of the claim that documents have been uploaded to the DMP.
Claims Processing	There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.

MI Health Link	For beneficiaries enrolled in the MI Health Link program, nursing facilities must still collect and maintain patient-pay amount offset information according to policy. Nursing facilities will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Nursing facilities should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.

8.2.D. Patient -Pay Amount Greater Than Amount Billed

Nursing facilities must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

8.2.E. Billed Facility Days

Day of Admission	Medicaid reimburses the day of admission if the beneficiary is counted in the facility census (e.g., if they are in the facility at midnight).
Day of Discharge	Medicaid does not reimburse the day of discharge unless the discharge is due to the resident's death. When billing, the facility must indicate "20" (expired) as the Patient Status Code. A discharge due to death is counted in the facility census.
Hospital Leave Days	▪ If the resident is expected to be in the hospital for 10 days or fewer and dies while in the hospital, the nursing facility may bill for the hospital leave days up to the day before the resident died. ▪ For Medicaid to pay for hospital leave days, Medicaid must have been paying for the nursing facility stay before the beneficiary was admitted to the hospital. ▪ If the resident returns to the nursing facility under Medicare coverage, the facility may bill for the hospital leave days if the emergency hospitalization was for ten days or fewer. ▪ A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is readmitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.
One-Day Stay	A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

Outpatient and Emergency Room	A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, and this day may be billed to Medicaid even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

8.3 Hospital Leave Days

For Hospital Leave Days, Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.50 percent occupancy may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent. Hospital leave days are limited to a total of 10 days per admission to the hospital for emergency medical treatment. The patient must return to the nursing facility in 10 or fewer days in order for the nursing facility to bill for hospital leave days. When billing, the facility must use:

- Revenue Code 0185; and
- Occurrence Span Code 74, with dates representing the leave days.

8.4 Therapeutic Leave Days

Therapeutic leave days are limited to a total of 18 days during a 365-day period. When billing, the facility must use:

- Revenue Code 0183; and
- Occurrence Span Code 74, with dates representing leave days.

8.5 Ventilator Dependent Care Unit (VDCU) and Complex Care

When billing for approved VDCU care or complex care:

- Facilities must enter the PA number from the Medicaid authorization form on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy. If a beneficiary is approved for ventilator care and also requires therapy, prior authorization for the therapy must be obtained under the VDCU NPI. Both the therapy and VDCU prior authorization numbers may be reported on the same claim.
- Facilities must bill with the appropriate daily care accommodation revenue codes. For ventilator dependent care, revenue code 0110 must be used. For complex care, revenue code 0120 must be used. Providers should contact MDHHS Long Term Care Operations for information on ventilator dependent care and/or complex care. (Refer to the Directory Appendix for contact information.)

For Medicare-Medicaid nursing facility crossover claims, refer to the Medicare-Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits) and the Ventilator-Dependent Care Units subsections for additional information regarding ventilator-dependent care units.

8.6 Facility Under New Ownership

If a facility changes ownership, the facility must register the NPI for the new owner through the on-line CHAMPS Provider Enrollment (PE) subsystem. If the provider tax identification number (TIN) did not change, the NPI can be reported through the CHAMPS PE maintenance function. If the change involves a new TIN, the provider must complete a new enrollment application. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for enrollment information.)

If the facility changes ownership in the middle of the month and the beneficiary was in continuous residency at the facility for the month, the facility must submit a claim using the old provider NPI number for the first part of the month and another claim for the second part of the month using the new provider NPI number. The process for two facilities and two claims in a month should be followed for beneficiaries with patient-pay amounts. (Refer to the Patient-Pay Amount subsection above for additional information.)

8.7 Beneficiary Transfer

When a beneficiary is transferred from one facility to another, MDHHS recommends that the second facility obtain the therapeutic leave day record and Medicare status for the year from the first facility. Maintenance of these records allows the second facility to bill properly and prevents unnecessary rejections.

8.8 Hospital Swing Beds

Providers of Medicaid swing bed services may not bill for swing bed days unless the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital diagnosis related group (DRG) of the admission.

- The admission date on the claim is the date the beneficiary was admitted to the swing bed. A beneficiary may not be admitted to the swing bed until discharged from an acute care bed.
  - The admission date to the swing bed is not included in the billing period if the admission date to the swing bed is within the DRG coverage period.
- The "from" date and "through" dates on the claim are the beginning and end dates of the billing period. No more than one calendar month may be billed on a claim. The billing period for a Medicaid covered swing bed stay begins when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital DRG for the hospital admission.
- Hospitals that are exempt from the DRG system may bill for Medicaid covered swing bed days beginning the day of admission to the swing bed.
- The units of service entered on the claim is the number of swing bed care days provided. The day of admission to the swing bed may not be included in the billing period. To determine if the admission date is included in the billing period, refer to the instruction (above) for the "from" date.
- The total number of swing bed care days is limited to 100 days per beneficiary per stay.

8.9 Cost Settled Provider Detail Report (FD-622)

A Cost Settled Provider Detail Report (FD-622) is available to nursing facilities (nursing homes, county medical care facilities, hospital long-term care units, ventilator-dependent care units, and hospital swing beds). The FD-622 provides detailed information of a facility's charges paid by Medicaid. Since MDHHS acts as a fiscal agent for many different sources of payment, the FD-622 includes all of these sources.

This report can be used in conjunction with the Remittance Advice (RA) to reconcile the accounts receivable and used as the actual log that the facility must maintain for Medicaid, eliminating duplication of paperwork by the facility.

The FD-622 includes:

- Medicaid payroll information
- the facility's billing information
- the facility's current interim reimbursement rate
- beneficiary information on services billed to Medicaid
- summary of cost settled services
- total charges billed to Medicaid
- amount paid by Medicare, other insurance, beneficiary
- Medicaid payments
- gross adjustments
- Medicaid claim statistic information

The detail portion of the FD-622 report is available in an electronic version. Additional information is available on the MDHHS website. (Refer to the Directory Appendix, Nursing Facility Resources, for website information.)

8.10 Daily Care

The following providers may bill for daily care and must enter the appropriate revenue code that identifies the specific daily care accommodation being billed:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units
- Hospital Swing Beds
- Ventilator Dependent Units
- State Veterans' Homes

The NUBC Manual provides the revenue codes to be used for Michigan Medicaid.

8.11 Ancillary Physical and Occupational Therapy, Speech Pathology

Ancillary services can be billed on the same claim as daily care (room and board).

The following providers may bill physical/occupational therapy and speech pathology:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units
- Outpatient County Medical Care Facilities
- Ventilator Dependent Units
- State Veterans' Homes

When billing on the NUBC claim form, facilities must use the revenue codes and HCPCS codes identified on the MDHHS Therapy Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.)

- Each ancillary service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a:
  - Date of service
  - Revenue code and a HCPCS code
  - PA number on the claim
  - Therapy discipline modifier
  - Therapy nature modifier (habilitative claims only)
- PA number must be on the claim.

When billing, facilities must enter the PA number from the Medicaid authorization form on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy.

Therapy services must be reported using the appropriate therapy modifier to distinguish the discipline under which the service is delivered. In addition, when services are habilitative, they must be reported with the appropriate modifier that represents the nature of the therapy. Maintenance therapy visits should also include the MDHHS designated maintenance modifier. Refer to the Therapy Services chapter for additional information related to therapies.

- Occupational therapy modifier: GO
- Physical therapy modifier: GP
- Speech therapy modifier: GN
- Rehabilitative therapy modifier: 97
- Habilitative therapy modifier: 96
- Maintenance visit modifier: TS (Follow-up Service)

8.12 Outpatient County Medical Care Facilities

- When billing for therapies, outpatient county medical care facilities must indicate the Type of Bill as 23X.
- Each service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a revenue code and a CPT/HCPCS code.
- Each claim requires a PA number to be reported in the appropriate form locator or electronic segment.

8.13 Medicare Part B Coinsurance and Deductible Amounts

The following providers are allowed to bill Medicaid for Medicare Part B coinsurance and deductible:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units

For the following revenue codes, Medicaid reimburses for any Medicare Part B coinsurance and deductible amounts, based on Medicare's payment, up to Medicaid's maximum amount allowed. Also, Medicaid covers the coinsurance and deductible amounts on any Medicare covered services not normally covered by Medicaid. When billing, each claim line requires a CPT/HCPCS code and the date of service (DOS).

If a beneficiary has Medicare Part B coverage and Medicare does not cover the service(s), the service(s) is considered routine nursing care.

Allowed Revenue Codes: 0270, 0272, 0274, 0275, 0276, 0300 - 0359, 0400 - 0409, 0420 - 0449, 0460, 0469, 0480 - 0489, 0610 - 0619, 0636, 0730 - 0749, 0780, 0800 - 0809, 0920 - 0929, 0940 - 0949.

8.14 Other Service Revenue Codes

Other service revenue codes may be billed as indicated below:

- 0160 - For dually eligible beneficiaries who wish to return to their Medicaid NF bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

  Services for nursing facility beneficiaries requiring outpatient physical therapy, outpatient speech pathology, and outpatient occupational therapy must be provided and billed under Medicare

Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

- 0410 - Oxygen (gas, equipment, and supplies) for frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day - covered when billed by a county medical care facility or hospital long-term care unit).

  The rental of a concentrator is billable by a Medical Supplier and should not be confused as needing to be billed under Revenue Code 0410.

  Interim reimbursement is based on a percent of charge. Final reimbursement is calculated during the respective period's cost settlement and is based on that period's audited cost to charge ratio.

  Medicare/Medicaid – If Medicare is being billed for the nursing facility stay, neither the nursing facility nor a medical supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

- Telemedicine – To be reimbursed for the originating site facility fee, the NF must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine facility fee and modifier. Refer to the Telemedicine Chapter for additional information. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

8.15 Part A Co-insurance Rate for Nursing Facility Care

Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).

8.16 Medicare - Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits)

MDHHS accepts institutional crossover claims from the Coordination of Benefits Contractor, Group Health Incorporated (GHI).

The institutional nursing facility crossover claim process allows nursing facilities to submit a single claim for residents dually eligible for Medicare and Medicaid. After processing the Medicare portion, GHI forwards the claim to Michigan Medicaid for processing and reimbursement.

A remittance advice (RA) is generated from Medicare with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark code does not appear on the Medicare RA, a separate claim must be submitted to MDHHS.

Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days. The facility may check claim status online through CHAMPS. If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDHHS showing all Medicare payment information.

Providers must resolve denied claims with Medicare when there is a denied Medicare service not covered by Medicaid. The excluded Medicare service covered by Medicaid should be billed directly to Medicaid.

The following claims are excluded from the crossover process:

- Original Medicare claims paid in full without deductible or co-insurance remaining
- Claims with private and commercial insurance
- Adjustment claims fully paid without deductible or co-insurance
- Original Medicare claims paid at greater than 100% of submitted charges without deductible or co-insurance remaining
- 100% denied original claims
- 100% denied adjustment claims, with no additional beneficiary liability
- 100% denied original claims, with additional beneficiary liability
- 100% denied adjustment claims, with additional beneficiary liability
- Adjustment claims
- Mass adjustment claims - other (monetary or non-monetary)
- Medicare secondary payer cost-avoided (fully denied) claims
- Claims reporting Revenue Code 0160 (Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay)

NOTE:

- For any Medicare Part B services associated with this nursing facility claim, the facility would bill Medicare accordingly.
- Nursing facilities must continue to complete their claims as they have been doing for Medicare.
- Nursing facilities must report the beneficiary's patient-pay, any offset to the patient-pay amount, and voluntary payments on the claim submitted to Medicare.
- When reporting ancillary services, the facility must indicate the service date on the line level of the claim. (Refer to applicable subsections in this chapter for additional information regarding ancillary services.)

8.16.A. Ventilator-Dependent Care Units

Medicaid-enrolled ventilator-dependent care units have a distinct National Provider Identifier (NPI) number for Medicaid billing. The number is separate from the "regular" facility NPI number. The facility would use the "regular" NPI number to bill days 1 to 100 to Medicare. Starting on day 101, the facility would bill Medicaid directly using its ventilator-dependent care unit distinct NPI number.

Additional information regarding crossover claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

NOTE: A Level of Care Determination (LOCD) must be completed for each NPI.

8.17 Reporting Medicare on the Medicaid Nursing Facility Claim

When reporting Medicare, nursing facilities must bill as outlined below.

- Covered Days
  - Covered days must be reported using Value Code 80.
  - Covered days are the days in which Medicare approves payment for the beneficiary's skilled care. Covered days must be reported when the primary insurance makes a payment.
- Non-Covered Days
  - Non-covered days must be reported using Value Code 81.
  - Non-covered days are the days not covered by Medicare due to Medicare being exhausted or the beneficiary no longer requiring skilled care. Non-covered days must be reported in order to receive the proper Medicaid provider rate payment.
  - When Medicare non-covered days are reported because Medicare benefits are exhausted, facilities must report Occurrence Code A3 and the date benefits were exhausted, along with Claim Adjustment Reason Code (CARC) 96 (Non-Covered Charges) or 119 (Benefit Maximum for the Time Period has been Reached).
  - When Medicare non-covered days are reported because Medicare active care ended, facilities must report Occurrence Code 22 and the corresponding date Medicare active care ended, along with CARC 96 or 119.
- Coinsurance Days
  - Medicare coinsurance days must be reported using Value Code 82.
  - Coinsurance days are the days in which the primary payer (Medicare or Medicare Advantage Plan) applies a portion of the approved amount to coinsurance. Coinsurance days must be reported in order to receive the proper coinsurance rate payment.
  - When reporting Value Code 82, Occurrence Span Code 70 (Qualifying Stay Dates for SNF) and corresponding from/through dates (at least a three-day inpatient hospital stay which qualifies the resident for Medicare payment of SNF services) must also be reported.
  - Facilities billing for beneficiaries in a Medicare Advantage Plan must report CARC 2, and this must equal the Medicare Advantage Plan coinsurance rate times the number of coinsurance days. Facilities using CARC 2 must report it with the amount equal to the coinsurance rate times the number of coinsurance days reported.
  - Medicare Advantage Plan coinsurance rates vary and do not always equal the Medicare Part A coinsurance rate. Providers must verify the beneficiary's Medicare Advantage Plan coinsurance rate prior to billing Medicaid.
- Prior Stay Date
  - If a SNF or nursing facility stay ended within 60 days of the SNF admission, Occurrence Span Code 78 and the from/through dates must be reported along with Occurrence Span Code 70 and the from/through dates.

- Nursing Facilities with Medicaid-Only Certified Beds Not Billing Medicare
  - For nursing facilities with Medicaid-only certified beds not billing Medicare, claims submitted directly to Medicaid must be billed as outlined above. For example, for beneficiaries with Medicare coverage based on Medicaid's TPL file, covered days must be left blank if Medicare is not covering the service or benefits have exhausted as Medicare is the primary payer. The non-covered day must be completed and it must equal the service units billed for room and board revenue codes and/or leave days revenue codes.

    The reason Medicare is not covering the service (e.g., benefits exhausted) must also be reported.

8.18 Long-Term Care Insurance

Federal regulations require that all identifiable financial resources available for payment, including long-term care insurance, be billed prior to billing Medicaid. If a beneficiary has long-term care insurance, it must be reported as other insurance on the Medicaid claim. (Refer to the Coordination of Benefits chapter for additional information.)

8.19 Monies Received from a Beneficiary and Reported with Value Code 22

When a nursing facility uses Value Code 22 – Surplus to report monies received from a beneficiary, beneficiary's family, or beneficiary's legal representative, the facility must also report these monies to the beneficiary's case worker at MDHHS. This must be reported in order for the case worker to evaluate whether or not the money is countable toward the Medicaid asset limit for Medicaid eligibility.
When reporting Value Code 22, the facility must report in the "Note" portion of the claim a detailed description of the monies received. The date that the nursing facility contacted the case worker must also be reported in the "Note" portion of the claim.

8.20 State Veterans' Homes

In addition to customary billing requirements, a State Veterans' Home must report:

- revenue code 0022,
- the five-digit Health Insurance Prospective Payment System (HIPPS) code,
- the Assessment Reference Date (ARD),
- the number of covered days for each HIPPS code, and
- occurrence code 50.

Revenue code 0022 must be reported on the same service line as each HIPPS code. The five-digit HIPPS code reported on the claim represents (in this exact order) the PT/OT score, the Speech-Language Pathology (SLP) score, the Nursing score, the Non-Therapy Ancillary (NTA) score and the Minimum Data Set (MDS) assessment type. HIPPS codes for the PT/OT, SLP, Nursing and NTA scores can be found in the Medicare Claims Processing Manual. The MDS assessment type should always be an Omnibus Budget Reconciliation Act (OBRA) assessment which has a value of 6, so the fifth digit of the HIPPS code should always be 6 on the claim. The service units on the service line must contain the number of covered days for each HIPPS code. Patient Driven Payment Model (PDPM) categories and AIs are determined by the

MDS 3.0 and can be found in the MDS 3.0 Resident Assessment Instrument (RAI) Manual. (Refer to the Directory Appendix for RAI Manual information.)

The federally required OBRA MDS assessments listed in A0310A of the MDS 3.0 RAI Manual are the only assessments that may be used for billing PDPM.

There must be an occurrence code 50 for each assessment period represented on the claim. The date of service with occurrence code 50 must contain the ARD associated with the applicable MDS assessment. Occurrence code 50 is not required with the default HIPPS code.

Providers must report the HIPPS code(s) and ARD(s) based on the applicable MDS assessment(s) to the billing period. Example: The provider is billing for April 1 through April 30, and MDS assessments occurred on March 15 and May 15. The HIPPS code and ARD would be based on the March 15 assessment since that was the assessment in effect when services were rendered.

Submitted claims will reject in the Community Health Automated Medicaid Processing System (CHAMPS). MDHHS will review the rejected claims and make periodic gross adjustments to the provider based on the claims data. MDHHS will adjust the gross adjustments as necessary to correct for past payments that do not conform to MDHHS billing and reimbursement policies.

Non-routine OT, PT and SLP services are included in the PDPM rates paid to State Veterans' Homes. These providers are to bill for non-routine therapies on the same claims as daily care, and they are required to obtain prior authorization.

The revenue code, HIPPS code, number of covered days for each HIPPS code, occurrence code 50, and the MDS ARD may be reported in the claim notes.

These billing requirements apply to State Veterans' Homes billing for NF services and hospice providers billing for room and board in a State Veterans' Home.

State Veterans' Homes are excluded from the reimbursement policy that requires Medicaid to pay the lower of the customary charge to the general public or the prospective rate determined by Medicaid.

SECTION 9 – HOME HEALTH CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing Home Health claims.

9.1 INTERMITTENT NURSING VISITS/AIDE VISITS/THERAPIES

Each visit must be reported on a separate claim line: Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines of the same claim).

Report 15-minute time increments: Medicaid follows Medicare policy for reporting home health visits in 15-minute increments. When billing on the NUBC form, each home health visit revenue code that is reported must have a corresponding 15-minute increment HCPCS code along with the number of 15-minute increments reported in the Service Units as follows:

Units	Time Requirements
1	1 minute to < 23 minutes
2	23 minutes to < 38 minutes
3	38 minutes to < 53 minutes
4	53 minutes to < 68 minutes
5	68 minutes to < 83 minutes
6	83 minutes to < 98 minutes
7	98 minutes to < 113 minutes
8	113 minutes to < 128 minutes

If services continue for longer periods of time, the home health agency would follow the above pattern.

Time of Service Visit: The timing of the visit begins at the beneficiary's home when services actively begin and ends when services are completed. The time counted must be the time spent actively treating the beneficiary. For example:

- If a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than three minutes), then the time the beneficiary spends on the telephone and not engaged in treatment does not count in the amount of service.
- The home health aide completed bathing and transferring the beneficiary into a chair, and now begins to wash the kitchen dishes before leaving. Washing the dishes is considered incidental and does not meet the definition of a home health aide service. Therefore, the time to perform this activity would not be included in the 15-minute incremental reporting to Medicaid.

Other nontreatment-related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel cannot be counted as treatment time.

However, if the professional spends time with family or other caretakers in the home teaching them to care for the beneficiary, this activity is counted as treatment time. Calls to the physician by the nurse while in the beneficiary's home to report on the beneficiary's condition can also be counted as treatment time.

If beneficiary assessment activities for completion of the Outcome and Assessment Information Set (OASIS) are a part of an otherwise covered and billable visit, time spent in beneficiary assessment may be included in the total count of 15-minute increments. Completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment but not to provide other covered home health services is not billable.

9.2 Postpartum/Newborn Follow-up Nurse Visit

- Medicaid allows one initial postpartum and one initial newborn visit per pregnancy. The initial postpartum visit must be billed using the mother's Medicaid ID number. The initial newborn visit must be billed using the newborn's Medicaid ID number.
- Medicaid allows one subsequent visit to the mother and newborn. This subsequent visit may be billed under either the mother's or newborn's ID number, based on with which beneficiary the nurse spent the majority of the time.

9.3 Intravenous Infusions

If the beneficiary is in need of intravenous infusion and an Infusion Clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or a family member/caregiver will not accept this task, the HHA may perform this service and bill accordingly.

These services must be billed as an Infusion Nurse Visit:

- Use Revenue Codes 0550, 0551, or 0552
- Use Procedure Codes:
  - 99601 (per visit - up to two hours). Must be billed on the first claim line.
  - 99602 (each additional hour). Must be billed on each additional claim line for each additional hour.

9.4 Home Health Procedure Codes

When billing on the NUBC claim form, home health agencies must use the HCPCS codes located in the Healthcare Common Procedure Coding System manual and the revenue codes in the UB-04 Manual. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

SECTION 10 – PRIVATE DUTY NURSING AGENCY CLAIM SUBMISSION/COMPLETION

10.1 DIRECT BILLING TO MDHHS

Providers must bill MDHHS directly (either paper or electronically) using the codes listed in the MDHHS Private Duty Nursing Reimbursement Rates Database posted on the MDHHS website. (Refer to the Directory Appendix for website information.) When direct billing to MDHHS, note the following:

Service Dates	Each date of service must be reported on a separate service line.
Units	Each service line must contain the number of units of care in the "Serv. Units" for that date of service.
Prior Authorization	The PA number listed on the Medicaid authorization letter must be recorded on the claim.
Authorization Letter	The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
Billable Units	PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15-minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.
Adjustments	Adjustments to claims are made through a total claim replacement or void/cancel process.
Multiple Beneficiaries Seen At Same Location	The total Medicaid reimbursement for multiple beneficiaries is time-and-one-half for two beneficiaries. The specific codes listed in the HCPCS Codes/Modifiers section of the MDHHS Private Duty Nursing Reimbursement Rates Database must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These codes must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary modifier code must be used for both children. When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."
Holidays	Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. A holiday begins at 12:00 am and ends at 12:00 midnight of that holiday day.
Other Insurance	If the beneficiary has other insurance, it must be reported on all claims to MDHHS.

10.1.A. Revenue Codes/HCPCS Codes/Modifiers

When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDHHS website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.)

10.1.B. Payment in 15-Minute Increments

Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.

SECTION 11 – HOSPICE CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing Hospice claims.

11.1 BILLING INSTRUCTIONS FOR HOSPICE CLAIM COMPLETION

- **Admission Date:** The Certification (start) date must be reported on every hospice claim. Use Occurrence Code 27 and the applicable date. Hospice claims submitted to MDHHS must be in date sequence order. Ensure payment is received for the initial hospice month prior to submitting claims for subsequent months.
- **Inpatient Respite Care:** "Occurrence Span Code" - include occurrence span code M2 and complete the "from and through" dates for an episode of inpatient respite care.
- **Core Based Statistical Area (CBSA):** "Value Codes" - include value code 61 in the value code field and report the CBSA number. Hospice claims must be reported with a valid CBSA code based on the location of the beneficiary receiving services.
- Use the Revenue Codes listed below:

Revenue Code	Description
0651	Routine Home Care I
0652	Continuous Home Care
0655	Inpatient Respite Care
0656	General Inpatient Care
0657	Physician Services
0658	Other Hospice I (Room & Board)
0659	Other Hospice Service – Facility Innovative Design Supplemental (FIDS) Bed

- Effective for dates of service on or after January 1, 2016, hospice routine home care is reimbursed as a two-tiered reimbursement rate:
  - A higher rate is paid for the first 60 days of hospice care
  - A decreased rate is paid for hospice days 61 and beyond

  A day of hospice is counted when any level of hospice care is provided (i.e., Routine Home Care, Continuous Home Care, General Inpatient Care, and Inpatient Respite Care). If a beneficiary is discharged from hospice but the discharge is not due to death, and the individual returns to hospice within 60 days of the discharge, the hospice day count will resume from the point that the beneficiary left hospice. If a beneficiary is discharged from hospice but returns after more than 60 days have elapsed, the count will reset to day one and the higher hospice routine home care rate for days 1 to 60 will be reimbursed. The count of hospice days does not reset if the beneficiary transfers to a different hospice provider.

- To bill for room and board in a nursing facility, licensed hospice long-term care unit, or Ventilator Dependent Care Unit (VDCU), use Revenue Code 0658. Providers must bill their customary room and board rate and Medicaid pays the usual and customary rate or the Medicaid fee screen, whichever is less. Room and board is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF. NOTE: In order for the hospice provider to complete the hospice beneficiary's admission, the type of facility for the VDCU must be identified as a nursing facility in the Admission Information Section in CHAMPS and include the VDCU's NPI. When a beneficiary resides in a VDCU/Dialysis Unit under which the VDCU has a special agreement with Medicaid and elects hospice, a prior authorization (PA) number for hospice is not required.
- To bill for room and board in a nursing facility when the beneficiary resides in a Facility Innovative Design Supplemental (FIDS) bed, use Revenue Code 0659.
- Revenue Code 0657 Physician Services requires inclusion of a HCPCS code on the claim line. Each Physician service must be billed on a separate claim line.
- Revenue Code 0652 Continuous Home Care must be billed for each date of service on separate claim lines. To receive the Continuous Home Care rate under code 0652, a minimum of 8 hours of care, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is reported under code 0651. A portion of an hour counts as an hour for this determination.
- Hospital Leave Days must be billed using Revenue Code 0185 (must not exceed 10 consecutive days). Reimbursement is at 100 percent of class-wide Nursing Facility Hospital Leave Day rate for qualifying facilities.
- Therapeutic Leave Days must be billed using Revenue Code 0183 (must not exceed 18 total days for the year) or Revenue Code 0189, Therapeutic Leave Days, for a beneficiary in a Facility Innovative Design Supplemental (FIDS) bed. Reimbursement is at 95 percent of Nursing Facility rate for leave days.
- Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. (See first bullet for instructions regarding room and board.)
- When billing for a hospice/NF resident who has been approved for complex care, bill revenue code 0120 and include the assigned PA number in F.L. 84, as obtained from the NF.
- Billing for Service Intensity Add-on (SIA): Effective for dates of service on and after January 1, 2016, the SIA rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by a Registered Nurse (RN) and/or Social Worker when the beneficiary is receiving routine home care. However, the total of combined time rendered by an RN and Social Worker will not be reimbursed more than four hours per day. For example, if an RN provides three hours of care and a Social Worker provides two hours during a given day, four hours will be reimbursed. The following items must be documented on the claim in order for the SIA to be paid:

  - Occurrence Code 55 with date of death
  - Appropriate discharge status code for death

- Revenue Codes and Healthcare Common Procedure Coding System (HCPCS) combinations representative of the RN or Social Worker visit:
  - RN: 0551 and G0299
  - Social Worker: 0561 and G0155
- Time of visit(s) recorded in units for the respective RN or Social Worker visit(s); one unit equals 15 minutes

The Michigan Medicaid program, including Medicaid Health Plans (MHPs) and MIChild, as well as CSHCS, covers hospice care for children under 21 years of age concurrently with curative treatment of the child's terminal illness when the child qualifies for hospice as described in the Hospice Chapter of this manual. Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. Each child's circumstances will need to be taken into consideration when making this distinction. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.

11.2 Application of the Patient-Pay Amount

CHAMPS handles the Patient-Pay Amount (PPA) in the following manner: When a beneficiary has a monthly PPA and a corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS. The PPA will be deducted from the first claim received in CHAMPS resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the location of the beneficiary at the first of the month. This will prevent the PPA from being deducted from the wrong claim.

Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.

The following examples are provided for application of the patient-pay amount (PPA).

Example 1: The beneficiary resides in a NF but is not receiving Medicaid hospice benefits. The beneficiary has a PPA of $500. The room and board for the NF is $125. The NF collects $500 from the beneficiary and provides the beneficiary with a receipt.

Example 2: The beneficiary resides in a NF and elects the Hospice benefit at the beginning of the month. The beneficiary has a PPA of $500. The hospice or the NF collects the $500 PPA from the beneficiary and applies it to the hospice room and board rate which includes the daily QAS amount ($150 which is $125 [NF rate] + $25 [QAS]). The hospice or the NF provides the beneficiary with a receipt.

Example 3: The beneficiary resides in a NF for the first two days of the month before electing the Hospice benefit. The beneficiary's PPA is $500. The NF collects the $500 from the beneficiary, applies $250 from the PPA (the NF rate of $125) toward the room and board owed the NF, and passes $250 on to the hospice. The hospice then bills, showing on its claim the $250 PPA balance available to be applied to the hospice room and board rate. The NF provides the beneficiary with a receipt.

11.3 Offset to Patient-Pay Amount for Noncovered Services

NOTE: This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.)

Claims containing an offset to patient-pay amounts cannot be split-billed. The hospice must submit one claim for the particular month of service.

The offset for the noncovered service must be reported on the claim using the appropriate value code and F.L. 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through CHAMPS.

The dollar amount of Value Code D3, minus Estimated Responsibility Patient (patient-pay amount), is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of $200 per month. The amount to be offset is $500. The amount to be offset would involve a three-month period. The first month claim would indicate $200 as an offset with D3 as zero. The second month claim would indicate $200 as an offset with D3 as zero. The third month claim would indicate $100 as an offset with D3 as $100.

11.3.A. Claim Documentation Requirements When Offsetting the Patient-Pay Amount

Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

Documentation Requirements	The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service. The hospice provider must upload the documentation to the Document Management Portal (DMP). The hospice provider is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.) **Note:** The hospice provider must report in the Note section of the claim that documents have been uploaded to the DMP.
Claims Processing	There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.

MI Health Link	For beneficiaries enrolled in the MI Health Link program, the hospice provider must still collect and maintain patient-pay amount offset information according to policy. Hospice providers will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Hospice providers should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.

11.4 Patient-Pay Amount Greater Than Amount Billed

Hospices must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

SECTION 12 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A RA is issued with each payment to explain the payment made for each claim. If no payment is due or claims have rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for DTMB website information.)

12.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA (835) has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment;
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or

change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.

For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.3 Paper Remittance Advice

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

12.4 Gross Adjustments

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

12.5 Claim Adjustment Reason/Remark Codes

When a claim is initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits which apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. Providers should review the definition of the codes to determine the reason for the rejection.

SECTION 13 - JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to the number of days after February 28. The next three leap years are 2028, 2032 and 2036.

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).

BILLING & REIMBURSEMENT FOR PROFESSIONALS

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SECTION 1 - GENERAL INFORMATION

This chapter applies to all providers billing the CMS-1500 or 837 Professional claim formats. It contains information needed to submit professional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDHHS actions.

The following providers must use the ASC X12N 837 5010 professional format when submitting electronic claims and the CMS 1500 claim form for paper claims.

- Advanced Practice Registered Nurses (APRNs), including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs)
- Ambulance
- Ambulatory Surgical Centers
- Anesthesiologist Assistants
- Certified Registered Nurse Anesthetists
- Chiropractors
- Community Mental Health Services Programs/Prepaid Inpatient Health Plans
- Family Planning Clinics
- Federally Qualified Health Centers
- Genetic Counselors
- Hearing Aid Dealers
- Hearing Centers
- Independent Diagnostic Testing Facilities
- Independent Laboratories
- Indian Health Centers
- Maternal Infant Health Program
- Medical Clinics
- Medical Suppliers
- Optical Companies
- Optometrists
- Oral-Maxillofacial Surgeons
- Orthotists and Prosthetists
- Physician Assistants
- Physical Therapists
- Physicians (MD & DO)
- Podiatrists
- Portable X-ray Suppliers
- Private Duty Nurses (Individually Enrolled)
- Rural Health Clinics
- School Services Program
- Shoe Stores
- Urgent Care Centers

Claims for services rendered as a result of an order or referral must contain the name and individual NPI of the provider who ordered or referred the service/item. The following are the authorized health professionals who may order, prescribe or refer services to Medicaid beneficiaries:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse
- Dentist
- Podiatrist
- Optometrist
- Chiropractor (limited to spinal x-rays only)

Examples of services that require an order, prescription or referral include, but are not limited to,:

- Ambulance non-emergency transports

- Ancillary services for beneficiaries residing in nursing facilities (e.g., chiropractic, dental, podiatry, vision)
- Childbirth/parenting and diabetes self-management education
- Consultations
- Diagnostic radiology services, unless rendered by the ordering physician
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Genetic Counseling
- Hearing and hearing aid dealer services
- Home health services
- Hospice services
- Independent Diagnostic Testing Facilities
- Laboratory services
- Certain mental health and substance abuse children's waiver services
- Certain Maternal Infant Health Program (MIHP) services
- Pharmacy services
- Portable X-ray Suppliers
- Private Duty Nursing services
- Certain school based services
- Therapy services (occupational therapy (OT), physical therapy (PT) and speech)
- Certain vision supplies

1.1 Claims Processing System

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and a combination of service edits. MDHHS uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated. Electronic claims filed by Wednesday may be processed as early as the next weekly cycle.

1.2 Predictive Modeling

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.

1.3 Claim Payment/Claim Status

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)

To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 Electronic Funds Transfer

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)

SECTION 2 - HOW TO FILE CLAIMS

Professional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837 5010 professional format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as the Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

2.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA compliant MDHHS standards, and submit the files to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA) that reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

2.1.B. Electronic Claims with Attachments

The Document Management Portal (DMP) in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for Medicaid electronic claims. (Refer to the MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required, providers must use the Document Management Portal to submit electronic attachments to MDHHS. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Consent forms (Consent for Sterilization [MSA-1959/HHS-687] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must be submitted through the Document Management Portal. (Refer to the Forms Appendix for copies of the forms and to the Directory Appendix for website information.) MDHHS will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. All consent forms must be submitted through the Document Management Portal.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

2.2 Paper Claims

The CMS-1500 form (02-12) must be used when submitting paper claims. It must be a form printed with red ink with the numbers OMB-0938-1197 FORM 1500 (02-12) in the lower right corner. Instructions for completing the CMS 1500 claim form are available on the NUCC website or through your CMS-1500 vendor. (Refer to the Directory Appendix for website information.)

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops
- Light print or print of different density
- Breaks or gaps in characters
- Ink blotches or smears in print
- Worn out ribbons

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. Guidelines to Complete Paper Claim Forms

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- Dates must be either the eight-digit format (MMDDCCYY) or the six-digit format (MMDDYY) without dashes or slashes as instructed by the NUCC manual. Be sure the dates are within the appropriate fields on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.

- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail CMS 1500 claim forms separately from any other claim form type.

2.2.B. Providing Attachments with Paper Claims

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

Claim attachments, such as medical records and EOBs, may be associated to a paper claim via the Document Management Portal. (Refer to the Directory Appendix for website information.)

Once confirmation is received that the consent forms are approved, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via Document Management Portal" must be included in the Remarks section of the paper claim.

Refer to the MDHHS website for Document Management Portal instructions, including fax requirements. (Refer to the Directory Appendix for website information.)

2.2.C. Mailing Paper Claims

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)

2.3 Reporting Provider NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., billing, referring/ordering, rendering and supervising) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). For a Type 2 (Organization) NPI, both the NPI and EIN must be reported at the billing provider loop for all electronic claims. For a Type 1 (Individual) NPI, both the NPI and EIN/SSN are required at the billing provider loop for electronic claims when a Type 2 NPI does not apply.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Organization) NPI is the number required for organizations (such as clinics, group practices, and incorporated individuals) who provide healthcare services and receive payment. For MDHHS, the Organization NPI must be reported in the billing provider loop or field. Also for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Organization) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the billing, referring/ordering, rendering, and supervising provider, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

2.3.A. Billing Provider

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

2.3.B. Rendering Provider

For claims requiring a rendering provider, the loop or field is mandatory. The rendering provider must be enrolled with the program for payment. If the rendering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Claims for services rendered by non-physician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.

School Services Program providers are exempt from this requirement and are not required to provide rendering NPIs on their claims.

2.3.C. Referring/Ordering Provider

Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s).

If the referring/ordering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement.

2.3.D. Supervising Provider

The supervising physician NPI may be a professional claim editing requirement for physician services rendered by an enrolled non-physician practitioner, such as a physician's assistant or advanced practice registered nurse. When physician collaboration or supervision is required by State law or Medicaid policy, claims must include the Medicaid enrolled supervising physician NPI. Refer to the Practitioner Chapter for additional information related to program requirements for supervision or physician collaboration for services provided by non-physician practitioners.

SECTION 3 - CLAIM COMPLETION

Instructions for completing the CMS 1500 claim form are available on the NUCC website or through your CMS-1500 vendor. (Refer to the Directory Appendix for website information.)

SECTION 4 - REPLACEMENT, VOID/CANCEL CLAIMS AND REFUND OF PAYMENT

4.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

A replacement claim must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDHHS made payment. When a replacement claim is received, MDHHS deletes the entire original claim and replaces it with the information contained on the replacement claim. All money paid on the original claim is debited and a new payment is issued based solely on information reported on the replacement claim.

Replacement claims should be submitted to:

- return an overpayment. (Provide an explanation of the reason for the overpayment in Remarks section.)
- correct information submitted on the original claim (other than to correct a provider NPI and/or beneficiary ID number). (Provide an explanation of what information is being corrected. Refer to the Void/Cancel Claims subsection below to correct errors related to a provider NPI and/or beneficiary ID number.)
- report payment from another source after MDHHS paid the claim. (Report the source of the payment (e.g., OI, Medicare, etc.) in the Remarks section.)
- correct information that the scanner misread (except a provider NPI or beneficiary ID number). (State reason in the Remarks section. Refer to the Void/Cancel Claims subsection below to correct provider NPI or beneficiary ID number errors.)

All claim completion instructions apply to completing a replacement claim. In addition:

- The provider NPI number and the beneficiary ID number on the replacement claim must be the same as on the original claim.
- Resubmission code 7 must be entered in the left side of Item 22 and the 18-digit Transaction Control Number (TCN) of the previously paid claim in the right side of Item 22. If either the resubmission code of 7 or the original TCN is missing, the claim cannot be processed as a replacement claim.

If all service lines of a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

4.2 VOID/CANCEL CLAIMS (ADJUSTMENTS)

A void/cancel claim must be submitted when a claim was paid under an incorrect provider NPI or beneficiary ID number. When void/cancel claims are received, MDHHS deletes the original claim and all money paid on the claim is debited.

When submitting a void/cancel claim:

- The provider NPI number and beneficiary ID number must be the same as on the original claim.
- Resubmission code 8 must be entered in the left side of Item 22 and the TCN of the previously paid claim in the right side of Item 22. If the resubmission code of 8 or the original TCN is missing, the claim cannot be processed as a void/cancel claim.

All claim completion instructions apply for completing a void/cancel claim except as noted below:

- Complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct beneficiary ID.

After the void/cancel claim is submitted, a new claim containing the correct provider NPI and/or beneficiary ID number may be submitted.

The MDHHS 12-month timely filing billing limitation policy applies to void/cancel claims. Refer to the Timely Filing Billing Limitation subsection of the General Information for Providers Chapter for additional information.

4.3 Refund of Payment

Return of overpayments made by MDHHS, due to either payment from a third-party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to **inactive** providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund.
- include the provider EIN (tax) number.
- be sent to the MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

A copy of the remittance advice corresponding to the original payment and/or a detailed statement explaining the reason for the return of the payment should accompany the check.

SECTION 5 - CHANGES IN ELIGIBILITY ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid or Children's Special Health Care Services (CSHCS) beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a MHP, from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

5.1 INPATIENT HOSPITAL ADMISSIONS AND SERVICES [CHANGE MADE 7/1/2025]

The following guidelines are intended to assist providers and health plans regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require authorization. All medical/surgical (nonpsychiatric) admissions must be authorized by the MDHHS Program Review Division (PRD) or by the Heath Plan the beneficiary is enrolled in at the time of the admission. The local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) must authorize all psychiatric admissions.
- Services provided during the admission may also require authorization for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests may not be reimbursed unless a health plan's authorization process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, any nonpsychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services once authorization has been obtained.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission, payment for all services provided until the date of discharge are the responsibility of the payer at the time of admission. Services provided after discharge are the responsibility of the new payer. Discharge planning should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a nonhospital setting.

The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted to the hospital on September 15, enrolled in a health plan on October 1, and discharged from the hospital on October 5. The health plan is not responsible for services until October 5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.
Health Plan to Health Plan with Transfer to a Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the patient develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP. During the admission, the beneficiary requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

(text deleted 7/1/2025)

Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)

5.2 Ongoing Services and Extended Treatment Plans

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new responsible party. Enrollment in a health plan always triggers an authorization process. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan with an exception for CSHCS/Medicaid beneficiaries with a Prior Authorization (PA) in place at the time of enrollment in the current health plan.

In order to preserve continuity of care, MHPs and Fee-For-Service (FFS) must accept PAs in place when the CSHCS/Medicaid beneficiary has a change in enrollment status. For CSHCS/Medicaid beneficiaries who have been in the FFS system and who have FFS PA in place at the time the MHP receives the enrollment file, MHPs are expected to honor the PA in place for 30 days after the effective date of enrollment. Full reciprocity is required between the party that originally authorized the service and the new payer for the first 30 days following the enrollment change. This includes accepting the approved provider, services, quantity limits, Medicaid rates and special rates, as well as other terms that have been negotiated for the beneficiary's care.

- The servicing provider is responsible for transmitting a copy of the previously approved PA to the new payer when there is a change in the beneficiary's enrollment status.
- If the prior authorized provider is not in the MHP network, the MHP must pay the out-of-network provider at the prior authorized rate for the first 30 days following the enrollment change. Providers may not bill FFS or the beneficiary for services covered by the MHP; the provider must bill the MHP.
- Providers must be enrolled with Medicaid to bill FFS. Providers may not bill the MHP or the beneficiary for services covered by Medicaid FFS; the provider must bill FFS.

For all other purposes, the health plan in which the beneficiary is enrolled must assess the need for continuing services and authorize as appropriate. Health plans should facilitate the transition between providers for all beneficiaries to ensure continuity of care.

In situations where a change in enrollment status occurs during a hospital admission, physician services provided during the admission are the responsibility of the payer for the admission.

The following are examples of situations that may occur while providing care to an eligible beneficiary.

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, MDHHS authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery as the plan is now the payer, not FFS. MDHHS authorization would be void.
Voluntary Health Plan Change During a Course of Treatment	A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. The provider cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

5.3 Durable Medical Equipment [Title Revised & Change Made 7/1/2025]

MDHHS policy directs providers to bill the date of delivery for durable medical **(text revised 7/1/2025)** equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks box on the claim. This is especially important when a beneficiary changes from FFS to a health plan.

SECTION 6 - SPECIAL BILLING

For professional claims, many of the coding conventions described in the CPT manual apply when submitting claims to MDHHS. Additionally, CMS guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid programs and CSHCS.

Do not send documentation with the claim unless it is a MDHHS requirement for processing the claim. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact Provider Inquiry for assistance. (Refer to the Directory Appendix for contact information.)

6.1 GENERAL INFORMATION [CHANGE MADE 7/1/2025]

Bundled Codes	MDHHS follows Medicare guidelines for bundled services. CPT procedure codes with a CMS status indicator of "B" indicate that payment for the covered service is always bundled into payment for other related services not specified. These bundled codes do not receive separate reimbursement. Status code indicators may be found in the RVU file on the CMS website. (Refer to the Directory Appendix for website information.)
Coding	All unlisted or not otherwise classified (NOC) codes require an explanation of the service/item provided. The explanation may be entered in the Remarks Section or may be provided as a claim attachment. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDHHS does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement. **Claims will be rejected for inappropriate recoding even if PA was issued by MDHHS.**
Diagnosis Coding	Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits. An external cause code cannot be reported as a primary diagnosis. If an external cause code is reported as primary, or if a code requires additional digits, the claim will reject.
Place of Service Codes	Use CMS approved two-digit place of service codes to report location for provision of covered services. MDHHS does not recognize the following place of service codes for reimbursement by the program: ▪ 05 – Indian Health Service Freestanding Facility ▪ 06 – Indian Health Service Provider-Based Facility ▪ 08 – Tribal 638 Provider-Based Facility ▪ 09 – Prison Correctional Facility ▪ **(text deleted 7/1/2025)**

	▪ 25 – Birthing Center ▪ 26 – Military Treatment Facility ▪ 53 – Community Mental Health Center ▪ 54 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Known as Intermediate Care Facility/Mentally Retarded (ICF/MR) by CMS] Additionally, some locations may be covered only for select providers. Refer to the appropriate provider-specific chapters of this manual for more information.
Prior Authorization	For elective services requiring PA, authorization must be obtained before providing the service. A letter approving or denying the service will be sent to the requesting provider along with a PA number, if approved. Do not submit the letter with the claim when billing. Report the PA number in item 23.

6.2 THIRD PARTY COVERAGE

Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Medicare Services	Medicare covered services must be submitted on one claim and any excluded services must be submitted on a separate claim. Do not mix covered and excluded services on the same claim. Providers must indicate Medicare's allowable amount as the charge (item 24F) and report the actual payment and/or deductible as instructed. If the beneficiary is in a Medicare risk HMO, the fixed copay must be entered in item 24F. Refer to the Coordination of Benefits Chapter for information regarding Medicare crossover claims.
Commercial Plan with Fixed Copay	If the beneficiary is in a commercial plan with fixed copays, the copay must be entered in item 24F.
Commercial Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in item 24F of the service line.
Spend-down	See Medicaid Deductible.
Evidence of Other Insurance Response	When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing MDHHS for covered services. If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.

Beneficiaries in a MHP or PIHP	MDHHS cannot be billed for copays, deductibles, or any other fee for services provided to beneficiaries enrolled in a MHP or who are receiving services under PIHP/CMHSP capitation. Payment for services must be obtained from the MHP/PIHP/CMHSP. For detailed information related to third party billing, including Medicare and commercial insurance, refer to the Coordination of Benefits Chapter of this manual.
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	When billing for injectable drugs that are covered as a pharmacy benefit by a third party payer but covered as a physician service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.

6.3 AMBULANCE

Wait Time	The appropriate number of time units must be reflected in the Quantity field. One time unit represents each 30 minutes of waiting time after the first 30 minutes. No additional payment is made for the first 30 minutes of waiting time (i.e., total waiting time of 1 hour 30 minutes = 2 time units). The Remarks section or claim attachment must include the following information: ▪ Total length of waiting time, including the first 30 minutes. ▪ Name and NPI of the physician ordering the wait. ▪ Reason for the wait.
Mileage	When billing a mileage code for trips totaling: ▪ Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles). ▪ 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy.

6.4 Ancillary Medical Services

National Drug Code (NDC) Reporting for Physician-Administered Drugs	A provider is required to report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician-administered drug on the electronic and paper claim formats. Coverage of a physician-administered drug (except an immunization) is limited to a drug product from a manufacturer who has a signed rebate agreement with the Centers for Medicare & Medicaid Services (CMS). A current listing of the manufacturers who have signed rebate agreements with CMS can be found on the CMS website. (Refer to the Directory Appendix for website information.) Providers are required to review the website for any changes. MDHHS will not provide an updated listing of manufacturers with signed rebate agreements with CMS. Providers can report decimals if they are part of the NDC supplemental information. The NDC information must be reported on Medicare crossover claims. Claims submitted with invalid or missing NDC information or an NDC by a manufacturer who does not have a signed rebate agreement with CMS will reject at the claim line level. Examples in billing the NDC supplemental information and the NDC 5-4-2 format can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)
	Electronic Claims: Providers must report the NDC supplemental information in the appropriate segments in the electronic format. Zero dollars (0.00) may also be reported as the NDC Unit Price. A provider who bills a procedure code with multiple NDCs (e.g., compound drug) must repeat the same HCPCS code on multiple service lines allowing each NDC to be reported. The prescription number must be listed on each service line (REF segment) to link this service as one compound drug. (Refer to the Directory Appendix for additional resources and website information.) **DDE Claims:** To report a procedure code with multiple NDCs (e.g., compound drug), the same HCPCS code must be repeated on multiple service lines, allowing each NDC to be reported. The prescription number must be reported on each service line to link this service together as one compound drug. **CMS 1500:** Providers must report the NDC supplemental information along with the procedure code in Items 24A - 24D on the CMS 1500. A provider can refer to the National Uniform Claim Committee (NUCC) 1500 Health Insurance Claim Form Reference Manual for Version 08/05 for further information. This manual is available on the NUCC website. (Refer to the Directory Appendix for website information.) Providers who bill a procedure code with multiple NDCs must report the first NDC supplemental information on the form in Items 24A - 24D and report subsequent NDC supplemental information in a claim attachment. Report "see attachment" in Item 19 on the CMS 1500 to indicate additional NDC supplemental information is being billed.

Injectable Drugs	If an injectable drug, except a vaccine, is administered on the same day as another service, the administration of the drug is considered a part of the other service and cannot be billed separately. The procedure code, its NDC supplemental information, and the cost of the drug are billed. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, then the 340B price must be reported on the claim. In addition, injectable drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6. If a nonspecific or not otherwise classified (NOC) code is billed, the NDC supplemental information must be reported in Items 24A - 24D of the CMS 1500 or in the appropriate segments of the electronic format. Do not recode injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing Medicaid unless MDHHS does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.
Injectable Drugs and Biological Products Not Covered by Medicaid Health Plans	When multiple medical services are provided in conjunction with a carved-out physician-administered drug, FFS claims will process for payment of the carved-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary's health plan for payment.
Chemotherapy Drugs	Chemotherapy drugs and the administration of the chemotherapy drugs must be billed separately. Separate payment is also made for chemotherapy administration by push and by infusion techniques on the same day. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, the 340B price must be reported on the claim. In addition, chemotherapy drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6. If a chemotherapy drug is billed under a nonspecific or not otherwise classified (NOC) code, the NDC supplemental information must be reported in Items 24A - 24D of the CMS 1500 or in the appropriate segment of the electronic format. Do not recode chemotherapy drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing unless Medicaid does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.
Immunizations	Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). Immunization administration is covered in addition to the vaccine even if an Evaluation and Management (E/M) visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) Program are free to providers so the charge for these vaccines must be reported as 0.00 (zero dollars). Medicaid FFS or the appropriate Medicaid Health Plan can be billed directly for immunizations provided to a child even if other insurance resources are available. The preventive pediatric diagnosis code(s) must be included on a claim to avoid a rejection.

Allergy Immunotherapy Services	For allergy immunotherapy services, only component services may be billed. Bill the number of doses of allergy extract or stinging insect venom prepared for and administered to the beneficiary on that date.
Component Billing	For diagnostic tests with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.

6.5 Anesthesia Services

Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the beneficiary is released by the anesthesia practitioner to the care of another physician or other qualified health care professional. (Refer to the Practitioner Reimbursement Appendix of this manual for information regarding the fee schedule rate calculation for anesthesia services.)

Anesthesia Base Units	Anesthesia base units represent the value assigned by the Centers for Medicare & Medicaid Services (CMS) to each anesthesia CPT code. Anesthesia base units account for all other activities other than anesthesia time which include usual pre-operative, intra-operative, and post-operative visits, administration of fluids and/or blood products incident to anesthesia care, and monitoring services. The anesthesia base units for each surgical procedure are specified in the anesthesia fee schedule and should not be included in the reported time units (quantity).
Anesthesia Time	Anesthesia time is defined as the period during which an anesthesia practitioner is furnishing continuous anesthesia care to the beneficiary. Time starts when the anesthesia provider begins to prepare the beneficiary for induction of anesthesia and continues throughout the case and while the anesthesia provider accompanies the beneficiary to the post-anesthesia care. Time stops when the provider releases the beneficiary to the care of the post-anesthesia care area personnel. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual time furnishing anesthesia care is counted. Anesthesia start and stop times must be documented in the medical record. Providers are to report actual anesthesia time in minutes on claims for reimbursement. The evaluation and examination of the beneficiary prior to surgery is considered part of the anesthesia service and included in the base unit value of the anesthesia code and is not to be reported in the anesthesia time.
Coding	Report anesthesia services with the five-digit CPT anesthesia codes. Only one primary anesthesia service should be reported for a surgical session. Use the anesthesia code related to the major surgery.
Modifiers	Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.

Anesthesia Add-on Codes	Anesthesia add-on CPT codes (e.g., 01953) are covered in addition to the primary anesthesia code. For all nonobstetrical anesthesia add-on codes, report time units under the primary anesthesia code. Reimbursement is a flat rate calculated using the base units multiplied by the State anesthesia conversion factor. Exceptions are obstetric anesthesia add-on CPT codes 01968 and 01969 which are reimbursed utilizing base units, time and the State anesthesia conversion factor. Obstetric anesthesia add-on CPT codes 01968 and 01969 are reimbursed utilizing base units, time and the State anesthesia conversion factor. For obstetrical anesthesia add-on codes, report the anesthesia time in minutes associated with the add-on code separately from the anesthesia time in minutes associated with the primary obstetrical anesthesia code.
Concurrent Surgical and Anesthesia Services	If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

6.6 Centering Pregnancy™ [Title Revised and Re-numbered 4/1/2025]

Medicaid may reimburse a maximum of 12 total in-person group sessions per pregnant beneficiary in addition to the required individual professional maternity visit when all the following criteria are met:

- The group visit is in addition to, and does not replace, the individual prenatal physical assessment visit;
- Group sessions are 90 to 120 minutes; and
- Documentation must support the actual time the pregnant individual spent in the group session.

One of the 12 group visits may be provided in relation to the postpartum professional visit.

Report group prenatal services as follows:

Visit Type	Group Prenatal Visits
Procedure Code	CPT 99078 Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable), educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
Modifier	TH - Obstetrical treatment/services, prenatal or postpartum

6.7 Children's Waiver Program [Re-numbered 4/1/2025]

Holiday Pay	Additional reimbursement is allowed under the Children's Waiver Program for Community Living Supports (CLS) and Respite Services performed on a holiday. Information regarding the specific procedure codes and associated holiday rates is available on the MDHHS website in the MDHHS CMHSP Children's Waiver Database. (Refer to the Directory Appendix for website information.) Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight.
Modifiers	Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDHHS CMHSP Children's Waiver Database on the MDHHS website for the appropriate modifier/procedure code combination. Refer to other billing instructions in this chapter for special circumstances requiring the use of a modifier.
Prior Authorization	Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Children's Waiver Section for information regarding prior authorization.
Respite Services to More Than One Beneficiary	When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim. If services are performed for more than one beneficiary at the same time by an LPN or RN, use the LPN/RN modifier, as appropriate, in addition to the TT modifier.
Units of Service	Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDHHS CMHSP Children's Waiver Database for the allowable units.

6.8 Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Program [Re-numbered 4/1/2025]

Holiday Pay	MDHHS allows additional reimbursement under the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program for Community Living Supports (CLS) and Respite Services performed on a holiday. Information regarding the specific procedure codes and associated holiday rates is available on the MDHHS website in the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database. (Refer to the Directory Appendix for website information.) Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight.
Modifiers	Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database on the MDHHS website for the appropriate modifier/procedure code combination.

Prior Authorization	Community Transition Services require prior authorization.
Services to More than One Beneficiary	A modifier is required to indicate that services were provided to more than one beneficiary at a time for Community Living Supports (CLS), Community Wraparound and Respite Services. When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim.
Units of Service	Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database for the allowable units.

6.9 Clinical Trials [Re-numbered 4/1/2025]

All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial. Claims must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) In addition, professional claims must include:

- ICD-10-CM Z00.6 (encounter for examination for normal comparison and control in clinical research program) in the primary or secondary position.
- Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim.
- Identify each line with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier.
  - HCPCS Modifier Q1 – routine clinical service provided in a clinical research study that is in an approved clinical research study.

Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational are not program covered services and should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim line with the appropriate modifier and a charge of $0.

- HCPCS Modifier Q0 - investigational clinical service provided in a clinical research study that is in an approved clinical research study.

Refer to the Billing & Reimbursement for Institutional Providers and the Practitioner chapters for additional information.

6.9.A. Reporting Covered Services [Re-numbered 4/1/2025]

Submit claims for services using the CMS 1500/837P professional claim format as follows:

Paper/direct data entry	Report the clinical trial number in FL 19.
Electronic claim form 837P	Report the clinical trial number in Loop 2300 NTE.

6.10 Community Health Worker Services [Re-numbered 4/1/2025]

CHW services are to be reported as follows:

- 98960 (education and training for patient self-management; individual patient)
- 98961 (education and training for patient self-management; 2-4 patients)
- 98962 (education and training for patient self-management; 5-8 patients)

These codes are to be reported in 15-minute increments and must be billed with the CG modifier to be considered for payment. One 15-minute increment equals one unit of service. The group size may not exceed eight beneficiaries.

Providers are asked to insert the following into the notes/comments section of the claim to provide additional information about the services being performed:

Claims Notes Section	Description (Based on Beneficiary Need – Covered Services)
C100	Chronic Health Condition – Health System Navigation and Resource Coordination
C200	Chronic Health Condition – Health Promotion and Education
C300	Chronic Health Condition – Screening and Assessment
C400	Chronic Health Condition – Other
S100	Social Need – Health System Navigation and Resource Coordination
S200	Social Need – Health Promotion and Education
S300	Social Need – Screening and Assessment
S400	Social Need – Other
P100	Pregnancy and up to 12 months Postpartum – Health System Navigation and Resource Coordination
P200	Pregnancy and up to 12 months Postpartum – Health Promotion and Education
P300	Pregnancy and up to 12 months Postpartum – Screening and Assessment

Claims Notes Section	Description (Based on Beneficiary Need – Covered Services)
P400	Pregnancy and up to 12 months Postpartum – Other
T100	Other Eligibility – Health System Navigation and Resource Coordination
T200	Other Eligibility – Health Promotion and Education
T300	Other Eligibility – Screening and Assessment
T400	Other Eligibility – Other

Medicaid-enrolled groups/organizations billing for CHW services must report the enrolled CHW as the rendering/servicing provider within the appropriate field on the Professional Claim Form CMS 1500. The CHW reported as the rendering/servicing provider must be enrolled in CHAMPS on the date of service reported on the claim.

6.11 Doula Services [Re-numbered 4/1/2025]

All claims for doula services must include an ICD-10 diagnosis code and HD modifier to support the services billed. In addition, doulas are encouraged to report the appropriate ICD-10 diagnosis codes within the range of Z55-Z56 to describe any relevant social determinants of health.

Visit Type	Procedure Code	Modifier	Primary Diagnosis Codes	Limit per Pregnancy
Prenatal Visits and Postpartum Visits	S9445	HD	Prenatal: Z33.1 Postpartum: Z39.2	12 total visits
Attendance at Labor and Delivery	T1033	HD	Z33.1	1 visit

6.12 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) [Re-numbered 4/1/2025]

6.12.A. Date(s) of Service [Re-numbered 4/1/2025]

Medical Supplies	For medical supplies, the date supplied must be reported as the date of service.
Diaper and Incontinent Supplier	For the Diaper and Incontinent Supplier Contract, the date the order is transmitted by the contractor to the fulfillment house is the date of service.
DME/Prosthetics/ Orthotics	For both custom and noncustom durable medical equipment (DME) and prosthetics and orthotics (P&O), the date of delivery must be reported as the date of service. For subsequent rental months, if applicable, the DOS must be the first day of the service month based on the original date of delivery.

Custom-Fabricated DME or P&O Appliances	For custom-fabricated DME or P&O appliances when there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time the item is ordered and is delivered, the order date rather than the delivery date must be reported as the date of service. For payment, the item must be delivered within 30 days after loss or change in eligibility.
Rented DMEPOS	For all rented DMEPOS, if a beneficiary's death occurs during a specific month in which payment has already been made, the prorating of actual days the items were used is not required.

6.12.B. Days or Units [Re-numbered 4/1/2025]

Continuous Passive Motion Device	For a passive motion device, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 21 days of rental may be considered for payment.)
Enteral Formula	For enteral formula (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total caloric units reported as the quantity. To determine the number of caloric units, divide the total number of calories of all cans to be used by 100.
Gradient Compression Stockings/Surgical Stockings	Gradient compression stockings are considered a "one item" service. The right (RT) and left (LT) modifiers must be used for these items when reporting HCPCS codes A6530 – A6549. When a gradient compression stocking is provided bilaterally, the same code is reported for both garments on one service line using modifiers LTRT with a quantity of "2". Surgical stockings and most gradient compression stockings are packaged by a pair and are billed with a quantity of "1" for each stocking. No RT or LT modifier is required for billing surgical stockings.
Home Intravenous Infusion Therapy	For home intravenous infusion therapy, HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted in the code description. A home infusion therapy code may be billed with modifier "SH" or "SJ" if multiple drugs are being administered concurrently (e.g., SH – 2 drugs, SJ – 3 drugs). Routine catheter care is included with the daily rate for the active infusion. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service.
Parenteral Intravenous Infusion Therapy	For parenteral intravenous infusion therapy, the appropriate HCPCS "B" codes must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other.

Powered Air Flotation Bed/Air-fluidized Bed	For a powered air flotation bed or air-fluidized bed, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 10 months of rental may be considered for payment.) For a powered air flotation bed or air-fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional six months of continued maintenance and servicing of the item has been provided. A quantity of "1" must be reported for the entire six-month period of service.

6.12.C. Hospital Discharge Waiver Services [Re-numbered 4/1/2025]

To bypass the PA requirement when billing for standard DME covered under the hospital discharge waiver service, report the discharge date in item 18. (The discharge date must be entered in the eight-digit MMDDCCYY format.)

6.12.D. Converting Rental to Purchase [Re-numbered 4/1/2025]

If the purchase of an item is requested after a previous rental month(s) has been paid, the provider must subtract all amounts previously paid from the total purchase price. Enter this amount in the charge field. Enter in the Remarks section that the item is converting from rental to a purchase. Do not enter any payment made by Medicaid in field 24k.

6.12.E. Place of Service Codes [Re-numbered 4/1/2025]

DMEPOS	Place of service codes acceptable to report for DMEPOS claims submitted by medical suppliers are as follows: ▪ 01 – Pharmacy ▪ 04 – Homeless Shelter ▪ 12 – Home ▪ 13 – Assisted Living Facility ▪ 14 – Group Home ▪ 16 – Temporary Lodging ▪ 31 – Skilled Nursing Facility ▪ 32 – Nursing Facility ▪ 33 – Custodial Care Facility

Nursing Facility Residents	For residents in a skilled nursing facility or a nursing facility, many medical supplies and/or items or DME are considered a part of the facility's per diem rate. For verification of specific procedure codes that may be billed by the medical supplier, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.) DMEPOS items for beneficiary use in the home and community may be delivered on the skilled nursing facility or nursing facility date of discharge. (Refer to the Medical Supplier Chapter for additional information.) The medical supplier must report the facility date of discharge in the relevant dates section of the electronic ASC X12N 837 5010 professional claim (loop 2300 DTP segment) or the Community Health Automated Medicaid Processing System (CHAMPS) direct data entry claim.

6.13 Evaluation and Management Services [Re-numbered 4/1/2025]

Coding	CPT E/M service guidelines apply for determining what level of care is appropriate. Generally, CPT descriptions for E/M services indicate "per day" and only one E/M service may be reported per date of service (DOS).
Preventive Medicine E/M Visit and Another E/M Visit on the Same Date	A preventive medicine E/M visit and another E/M visit on the same date are billed separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem-oriented E/M visit. When this occurs, bill the office/outpatient E/M procedure code using modifier 25 and bill the preventive E/M visit without using a modifier. Refer to CPT guidelines for additional information. If the same level of care E/M visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.
Procedures and New E/M Service	A procedure and a new patient E/M service on the same date should be reported using modifier 25 on the E/M service line.
EPSDT Developmental Screening	The developmental screening using an objective standardized tool is billed using the appropriate CPT E/M codes for the visit. A maximum of three screenings per beneficiary are allowed in one day by a single provider.
Consultations	Consultations require the referring/ordering provider's name and NPI in items 17 and 17b.
Office Emergency Services	To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E/M office visit that represents the level of care provided.
Hospital ED Reimbursement	E/M services provided in the hospital emergency department (ED) by the attending physician (MD, DO) are reimbursed on a two-tiered case rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen. Physicians must bill the level of service identified in the CPT coding descriptions to ensure proper reimbursement.
Miscellaneous	Services such as telephone calls, missed appointments, interpretations of lab results, and services of an interpreter cannot be billed as separate services or billed to the beneficiary.

6.14 Family Planning Clinics [Re-numbered 4/1/2025]

A Family Planning Clinic enrolled with a single billing NPI (representing both the Family Planning Clinic and any other enrolled provider specialty) must report the non-individual taxonomy code of 261QF0050X (Family Planning, Non-Surgical) to allow successful adjudication of family planning services. The taxonomy code must be reported at the header level of the claim, along with the billing provider NPI.

The taxonomy code must only be reported for family planning services. For non-family planning services, a separate claim must be submitted to MDHHS omitting the taxonomy code with the billing provider NPI.

6.15 Federally Qualified Health Centers [Re-numbered 4/1/2025]

A Federally Qualified Health Center (FQHC) enrolled with a single billing NPI (representing both the FQHC and Family Planning Clinic) must report the non-individual taxonomy code of 261QF0050X (Family Planning, Non-Surgical) to allow successful adjudication of family planning services. The taxonomy code must be reported at the header level of the claim, along with the billing provider NPI.

The taxonomy code must only be reported for family planning services. For non-family planning services, a separate claim must be submitted to MDHHS omitting the taxonomy code with the billing provider NPI.

6.16 Gender/Diagnosis Conflict [Re-numbered 4/1/2025]

Medical services are available to beneficiaries based on medical need regardless of how the beneficiary identifies or expresses for gender. Claims and encounters for some services may be inadvertently denied or rejected due to sex-specific editing unless billed properly.

Append modifier KX to professional claims and encounters for services that may pose a gender/diagnosis/procedure conflict or may be subject to related mismatch edits.

Fee-for-Service claims may also be reported with a diagnosis code from the gender identity category (F64), and these will suspend for review and payment.

6.17 Hearing Aids [Re-numbered 4/1/2025]

Delivery Date	The date of delivery of the hearing aid must be reported as the date of service. See Change in Eligibility below.
Change in Eligibility	When there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time a custom hearing aid is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

6.18 Hysterectomy [Re-numbered 4/1/2025]

Refer to the Surgery Section of this chapter for billing information.

6.19 Laboratory Services [Re-numbered 4/1/2025]

Panels	CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests as individual tests.
Blood Handling	On the CMS 1500 claim form, Box 19, Reserved for Local Use, must indicate the reason the blood was obtained as a separate service and the reason the laboratory that performed the testing could not also perform the venipuncture. For electronic claims, ANSI X12 837, Professional, documentation should be entered in the 2300 Loop, segment NTE02.
Referring/Ordering Provider	All clinical lab services billed to Medicaid must have a referring/ordering Medicaid provider name and NPI in items 17 and 17b.
CLIA Number	All clinical lab services billed to Medicaid must have a CLIA number in item 23.
Repeat Tests	If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second test on the next line with modifier 91. Medicaid does not pay for tests that are duplicated due to lab error.

6.20 Maternity Care Services [Re-numbered 4/1/2025]

Coding	CPT guidelines for reporting prenatal care and delivery services apply. Bill the global obstetrical package or the antepartum, delivery, and postpartum components as appropriate per Medicaid NCCI guidelines.
Delivery	Delivery is part of the global maternity package and should not be billed separately if the global package is billed. If the beneficiary is seen for fewer than seven antepartum visits, delivery and postpartum care should be billed separately. Use appropriate CPT guidelines.
Global Service	The global maternity package should be billed if the beneficiary is seen for seven or more antepartum visits with delivery and postpartum performed by the same physician or physician group. The provider or group may choose to bill the antepartum, delivery, and postpartum components separately as allowed by Medicaid NCCI editing.

Multiple Gestation	Per Medicaid NCCI guidelines, if multiple infants were delivered vaginally, report the appropriate CPT code for the initial delivery (global maternity care or vaginal delivery-only) on line one. Code additional vaginal deliveries as vaginal delivery-only. It is appropriate to append the code with modifier 59 (Distinct procedural service). If one infant is delivered vaginally and one or more delivered by cesarean, report the appropriate CPT code for the cesarean delivery (global maternity or cesarean delivery-only) on line one and the appropriate CPT code for the vaginal delivery (delivery-only) on line two. It is appropriate to append modifier 51 (Multiple procedures) to the vaginal delivery code. If multiple infants were delivered by cesarean delivery, report the appropriate CPT code for the cesarean delivery (global maternity care or cesarean delivery-only) on line one. When the delivery was significantly more difficult than usual, modifier 22 (Increased procedural service) may be appended to the delivery code. When modifier 22 is appended, documentation must support the substantial additional work and the reason for the additional work such as: ▪ Increased intensity or time ▪ Increased technical difficulty of performing the procedure ▪ Severity of the patient's condition ▪ Increased physical and mental effort required In instances of multiple births, providers should attach a copy of the medical records with the claim that supports the procedures performed. Providers must use a diagnosis code that represents the multiple birth.
Outpatient Lactation Support Provided by an Internationally Board Certified Lactation Consultant (IBCLC)	Claims are to be submitted utilizing the mother's Medicaid beneficiary identification number. Medicaid will reimburse for evidence-based lactation support services provided up to and through 12 months post-delivery. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. Medicaid will reimburse for the first eligible claims submitted for these services. IBCLC services may be billed as a separate and distinct service on the same date as which other services are rendered by a provider. Documentation must support a separately identifiable visit.
Physician Change During Antepartum Care	If the beneficiary changes physicians during the antepartum care (other than physicians within the same group), use the appropriate maternity CPT codes and guidelines for the services performed. The global package should not be billed by either physician regardless of the number of antepartum visits provided.
Postpartum Care	Postpartum care is included in the global maternity package and in the global surgical delivery period when the services are provided by the same physician or physician group. When the postpartum exam is performed by a physician not billing the global package or performing the delivery, the postpartum exam may be billed as a separate service.
Prenatal/Antepartum Care	If the beneficiary receives fewer than seven but greater than three antepartum visits, use the appropriate antepartum CPT code. Individual E/M codes should be used when three or fewer antepartum visits are performed.

6.21 Newborn Care [Re-numbered 4/1/2025]

When billing for medical services provided to the newborn, providers must use the newborn's Medicaid ID number, **except** if the delivering physician performs the newborn care and circumcision during the mother's inpatient stay, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

6.22 Private Duty Nursing (PDN) [Re-numbered 4/1/2025]

6.22.A. Direct Billing to MDHHS [Re-numbered 4/1/2025]

Providers must bill MDHHS directly (either paper or electronically) using the codes listed in the MDHHS Private Duty Nursing Reimbursement Rates Database posted on the MDHHS website. (Refer to the Directory Appendix for website information.) When direct billing to MDHHS, note the following:

Place of Service	The Place of Service Code on the claim must indicate "Home".
Service Dates	Each date of service must be reported on a separate service line.
Units	Each service line must contain the number of units of care in the "Days or Units" item for that date of service.
Prior Authorization	The PA number listed on the Medicaid authorization letter must be recorded on the claim.
Authorization Letter	The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter should not accompany the claim when billing.
Billable Units	PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15-minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.
Adjustments	Adjustments to claims are made through a total claim replacement or void/cancel process.
Multiple Beneficiaries Seen at Same Location	The appropriate code must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. This code must be used for **each** beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary modifier code must be used for both children. When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."
Holidays	Additional reimbursement for holidays on which private duty nursing services are provided is allowed. Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

Other Insurance	If the beneficiary has other insurance, it must be reported on all claims to MDHHS.

6.22.B. HCPCS Codes/Modifiers [Re-numbered 4/1/2025]

When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDHHS website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.

6.22.C. Payment in 15-Minute Increments [Re-numbered 4/1/2025]

Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.

6.23 Provider Preventable Conditions (PPCs) [Re-numbered 4/1/2025]

Coding	Providers must refer to the current CPT and HCPCS code books for the full descriptions of the national procedure codes and for additional explanatory information that may affect billing.
Modifiers	Every PPC service must have an appropriate HCPCS modifier reported on the service line. (Refer to the Modifiers section of this chapter for additional information.)

6.24 Radiology Services [Re-numbered 4/1/2025]

Bilateral	If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.
Multiple X-Rays	If the same x-ray is performed multiple times on the same beneficiary on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.
Component Billing	For radiology services with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.
Referring/Ordering Provider	Diagnostic radiology services that are a result of a physician's order or referral require the submission of the referring/ordering Medicaid provider name and NPI in items 17 and 17b.

6.25 School Services Program [Re-numbered 4/1/2025]

Units/Time	Procedure codes that specify time intervals cannot be billed until and unless the time unit specified is reached. Providers cannot bill less than a full unit or a partial unit and cannot round up to the next unit of service. For procedure codes billed by time units, such as per 15 minutes, the time specified in the procedure code description equals one unit of service. Procedure codes that are not billed by time units are billed per encounter.
Coding	Qualified staff may bill for assessments, tests and evaluations performed for the Individuals with Disabilities Education Act (IDEA) assessment using the appropriate procedure code with the HT modifier. The date of service is the date of the determination of eligibility for special education or early-on services. The determination date must be included in the assessment, test or evaluation.
IEP/IFSP	Qualified staff may bill for the multidisciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan using the appropriate procedure code and the TM modifier. The date of service is the date of the multidisciplinary team assessment.
Evaluations/ Assessments	Evaluations/assessments may be provided that are not related to the IDEA assessment or IEP/IFSP development, review, and revision. When this occurs, bill the appropriate evaluation/assessment procedure code for that profession with no modifier. The date of service is the date the evaluation/assessment is completed.
Multiple Disciplines on Same DOS	The psychologist, counselor, and social worker can bill for their evaluations/ assessments using the same procedure code for the same date of service. When this occurs, bill on one service line and indicate the total number of units provided for that date of service. The evaluations/assessments that are performed on the same day for the same student must be for different purposes and not duplicative. The date of service is the date the evaluations/assessments are completed.

6.26 Surgery [Re-numbered 4/1/2025]

Bilateral Procedures	When a bilateral procedure is performed and there is a bilateral CPT code available, the bilateral code must be used. When there is no code describing bilateral services, report the service on one line and use modifier 50. Use CPT guidelines for reporting modifier 50.
Coding	CPT surgery guidelines for add-on codes, separate procedures, and bilateral services generally apply.
Global Surgery	CMS global surgery guidelines apply. Use the appropriate modifiers to identify the service provided.

Hysterectomy and Sterilization Procedures	Hysterectomy and sterilization consent forms may be faxed to MDHHS for acknowledgement of proper completion and signatures before the service is billed. (Refer to the Directory Appendix for contact information.) If completed properly, there is no need to submit a copy of the form with the claim. Indicate "consent on file" in the Remarks section. For MHP enrollees, providers must contact that health plan for specific requirements related to these consent forms. The charge submitted to Medicaid for devices used in the sterilization process, permanent implantable contraceptive intra-tubal occlusion device and delivery system, must reflect the acquisition cost of the device and delivery system, including advertised discounts, special promotions, or other programs initiated to reduce prices for product costs (340B program). In addition, drugs purchased through the 340B program must be indicated on the claim using the modifier U6.
Identical Surgery/ Procedures on Same DOS	If two identical surgical or procedural services are provided on the same day to the same beneficiary and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.
Multiple Surgery	For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.
Post-0perative Care	When reporting post-operative care only for surgical procedures with 10-day or 90-day global periods, the provider assuming the post-operative care must bill the date of the surgery and the appropriate surgical code with modifier 55. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in the Remarks section.

6.27 TELEMEDICINE [RE-NUMBERED 4/1/2025]

Procedure code and modifier information for all telemedicine services is contained in the MDHHS Telemedicine Services Databases available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.27.A. ORIGINATING SITE [RE-NUMBERED 4/1/2025]

To be reimbursed for the originating site facility fee, the originating site provider must bill the telehealth facility fee. MDHHS will reimburse the originating site provider the current Medicaid fee screen. Additional services provided at the originating site on the same date as the telemedicine service may be billed and reimbursed separately according to published policy.

6.27.B. DISTANT SITE [RE-NUMBERED 4/1/2025]

Appropriate telemedicine modifiers must be used in conjunction with the appropriate CPT/HCPCS procedure code to identify the professional telemedicine services provided by the distant site provider.

6.28 Therapies (Occupational, Physical, Speech Language) [Re-numbered 4/1/2025]

Co-Treatment	One therapist can bill for the entire service, or the service units can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units billed must not exceed the total time the beneficiary received co-treatment services. Medical record documentation must substantiate treatment time billed by each discipline. If co-treatment therapy includes speech therapy services that are reported as an untimed session, they may be billed by the SLP as one unit. The therapy session must be at least 38 minutes in length to bill both speech therapy and occupational or physical therapy.
Evaluations and Re-Evaluations	Evaluations or re-evaluations may be billed with other therapy services on the same day. Therapy must be provided by the evaluating discipline.
Modifiers	Every therapy service must have an appropriate therapy modifier reported on the service line to distinguish the plan of care under which the service is delivered. When the therapy is habilitative in nature, services must be billed modifier 96. Maintenance therapy must also be reported with modifier TS.
Prior Authorization	Refer to the Therapy Services chapter for information regarding prior authorization. For MHP enrollees, the provider should check with the MHP for PA requirements.
Serial Casting	Serial casting must be billed under the manual therapy technique procedure code.
Units of Service	The service quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity.

6.29 Vision [Re-numbered 4/1/2025]

Routine Eye Examination	A routine eye examination includes, but is not limited to: ▪ Case history ▪ Determination of visual acuity (each eye) ▪ Ophthalmoscopy ▪ Biomicroscopy ▪ Ocular motility ▪ Tonometry ▪ Refraction ▪ Diagnosis ▪ Treatment program ▪ Disposition Ophthalmologists and optometrists must use appropriate CPT/HCPCS code(s) for the service

Nonroutine Eye Examination	Nonroutine eye examinations for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular conditions must be billed using the appropriate CPT/HCPCS codes.
Glaucoma Screening	Glaucoma screening must be billed with the appropriate CPT/HCPCS procedure codes. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening procedure code should not be used. A procedure code that best describes the encounter should be selected from the E/M or General Ophthalmological codes.
CPT/HCPCS Codes/Modifiers	Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding covered CPT/HCPCS codes.
Eyeglass Dispense Date	Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the eyeglasses must be reported as the date of service in item 24A.
Low Vision Services	When billing for low vision services, the low vision diagnosis must be designated as the primary diagnosis code on the claim service line. Covered low vision diagnosis codes are listed in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

SECTION 7 – MODIFIERS

Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. MDHHS recognizes two levels of modifiers:

- Level I modifiers are those included in CPT and updated annually by the American Medical Association (AMA).
- Level II modifiers are recognized nationally and updated annually by CMS.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT manual. Definitions of Level II modifiers are found in the annual edition of the HCPCS procedure coding manual. Providers should refer to these manuals and MDHHS provider manuals for specific information on the use of these modifiers.

The modifiers listed below must be reported when applicable. Modifiers affect the processing and/or reimbursement of claims billed to MDHHS for Medicaid programs and CSHCS beneficiaries. Other Level I and Level II modifiers may be used to provide additional information about the service or may be required by other payers but do not affect the processing of the Medicaid claim.

7.1 GENERAL BILLING GUIDELINES

Modifier	Description	Special Instructions
22	Increased Procedural Services	Providers may report when the work required to provide a service is substantially greater than typically required. Documentation/remarks required.
99	Multiple Modifiers	Identifies that more modifiers are necessary than allowed by the format (2 on paper claims or 4 in the electronic format). The second or fourth modifier must be "99" and the additional modifiers must be indicated in item 19 or the appropriate electronic remark area.
EP	Service provided as part of Medicaid EPSDT program	Report to identify EPSDT services.
GC	Service performed by resident under direction of teaching physician	Report to identify services provided by resident in presence of teaching physician.
GE	Service performed by resident under primary care exception	Report to identify primary care services provided by a resident without the presence of the teaching physician under the primary care exception.
HD	Pregnant/parenting program	Report to identify doula services
LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.

Modifier	Description	Special Instructions
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
TS	Follow-up service	Used with procedure code T1029 to determine reimbursement.
UN	Two patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UP	Three patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UQ	Four patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UR	Five patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
US	Six or more patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.

7.2 AMBULANCE

7.2.A. ORIGIN AND DESTINATION MODIFIERS

When billing for ambulance services, appropriate origin and destination modifiers must be included on any service line when billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code (e.g., use modifier RH for a transport from the residence to the hospital).

Modifier	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)

Modifier	Description
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

7.2.B. Multiple Transports Per Beneficiary

When a beneficiary requires more than one ambulance transport on the same date of service, providers must report:

- the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and
- the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles.

If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transport subsection of the Ambulance Chapter of this manual.

7.2.C. Multiple Patients Transport

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported.

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.

7.3 Anesthesia

Billing modifiers must be reported for each anesthesia service billed to Medicaid and will determine the level of reimbursement for anesthesia services. Each claim line for anesthesia services must include one of the modifiers described in the table below. The modifier will generate a calculated fee screen as described under "Special Instructions." Anesthesia services billed without an appropriate modifier are rejected.

Modifier	Description	Special Instructions
47	Anesthesia by Surgeon	Anesthesia procedure codes billed with this modifier are not paid. General anesthesia provided by the surgeon is not covered.
AA	Anesthesia Services Performed Personally by Anesthesiologist	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 100 percent.
AD	Medical Supervision By a Physician: More Than Four Concurrent Anesthesia Procedures	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be a flat rate calculated using the base units multiplied by the State anesthesia conversion factor.
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent.
QS	Monitored anesthesia care service	Informational only. Report in addition to payment associated anesthesia modifiers when Monitored Anesthesia Care (MAC) is provided. Modifier QS, used for informational purposes, must be reported as the second modifier on the claim line. If QS is the only anesthesia modifier reported, the claim will be rejected.
QX	Certified Registered Nurse Anesthetist (CRNA) / Anesthesiologist Assistant (AA) service with medical direction by a physician / anesthesiologist	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent. Anesthesiologist Assistant must be medically directed by an anesthesiologist.
QY	Medical direction of one CRNA/AA by an anesthesiologist	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent.
QZ	CRNA service: without medical direction by a physician	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 100 percent. Report for CRNAs practicing independently and for nonmedically directed services.

7.4 Children's Waiver Program

Modifier	Description	Special Instructions
TD	RN	Report in addition to the appropriate procedure code for respite when a registered nurse provides the service.
TE	LPN/LVN	Report in addition to the appropriate procedure code for respite when the service is provided by a licensed practical nurse.
TT	Individualized service provided to more than one patient in the same setting	Report in addition to the appropriate procedure code for respite when more than one beneficiary is receiving the service at the same time from the same provider.

7.5 Component Billing

Modifier	Description	Special Instructions
26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.
TC	Technical Component	Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.

7.6 DMEPOS

7.6.A. Surgical Dressings

For surgical dressings, report modifiers A1 through A9 depending on number of wounds being treated.

Modifier	Description	Special Instructions
A1	Dressing for one wound	Use to report surgical dressings
A2	Dressing for two wounds	Use to report surgical dressings
A3	Dressing for three wounds	Use to report surgical dressings
A4	Dressing for four wounds	Use to report surgical dressings
A5	Dressing for five wounds	Use to report surgical dressings
A6	Dressing for six wounds	Use to report surgical dressings
A7	Dressing for seven wounds	Use to report surgical dressings
A8	Dressing for eight wounds	Use to report surgical dressings
A9	Dressing for nine or more wounds	Use to report surgical dressings

7.6.B. New/Used DME

Modifier	Description	Special Instructions
KH	DMEPOS item, initial claim, purchase or first month rental	Use with HCPCS code E0604 for first month of rental only. Use with HCPCS code A9274 for initial claim only.
NU	New DME equipment	Use for the purchase of a new DME item. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the NU modifier.)

Modifier	Description	Special Instructions
UE	Used durable medical equipment	Use for the purchase of used DME equipment. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the UE modifier.)
RR	Rental (use the "RR" modifier when DME is to be rented)	For monthly rental rate of DME items.

7.6.C. Lower Extremity Prostheses

For all lower extremity prostheses, modifiers "K0" through "K4" must be reported to designate the potential functional ability of a beneficiary (before a prosthesis is furnished) based on the reasonable expectations of the prosthetist and treating physician.

Modifier	Description
K0	Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
K1	Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Lower extremity prosthesis functional level 2 – has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
K3	Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Lower extremity prosthesis functional level 4 – has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

7.6.D. Orthotic and Prosthetic

For orthotic and prosthetic items, the "LT" or "RT" modifier is required to designate either the left or right side of the body, if applicable. When reporting bilateral orthotic or prosthetic items on the same DOS, the "LT" and "RT" modifiers must be listed on the same service line with the combined quantities of both items. To verify the specific HCPCS codes that require these modifiers, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

Modifier	Description	Special Instructions
LT	Left Side of the Body (used to identify procedures performed on the left side of the body)	Must be reported with select prosthetic and orthotic items to identify the left side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.
RT	Right Side of the Body (used to identify procedures performed on the right side of the body)	Must be reported with select prosthetic and orthotic items to identify the right side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.

7.6.E. DME

Modifier	Description	Special Instructions
RA	Replacement of a DME item	Replacement of a DME when a significant change in the beneficiary's condition occurs prior to replacement limit.
RB	Replacement of a part of a DME furnished as part of a repair	Includes cost of the part and the labor associated with its replacement and finishing.

7.6.F. Powered Air Flotation/Air-Fluidized Bed

Modifier	Description	Special Instructions
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Use with HCPCS code E0193 or E0194 after six months of continued maintenance and servicing following the initial 10 months of rental. A quantity of "1" must be entered in the quantity field for the full six-month period of service.

7.6.G. Enteral Nutrition

Modifier	Description	Special Instructions
BO	Orally administered nutrition, not by feeding tube	Use to report oral administration of enteral nutrition.
U3	Medicaid State Defined Level 3 used with B4087 (low profile ext.) or with B4155 (formulas specific to inborn errors of metabolism)	Refer to the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule and the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.) Note: The beneficiary must have an inborn errors of metabolism diagnosis to receive manual payment for B4155 with the U3 modifier.

7.6.H. Infusion Therapy

Modifier	Description	Special Instructions
SH	Second concurrently administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify two concurrently administered drugs.
SJ	Third or more concurrently administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify three or more concurrently administered drugs.

7.6.I. Miscellaneous Supplies

Modifier	Description	Special Instructions
KX	Specific required documentation on file.	Append to each HCPCS code A4253/A4259 when submitting claims for over quantity for adults (age 21 and older) with medical need to test their blood glucose more frequently than established quantities. Append to specified HCPCS codes that require a face-to-face visit. Refer to the Medical Supplier Chapter and the Medicaid Code and Rate Reference tool in CHAMPS for all coverage requirements.
U3	Medicaid State Defined Level 3 used with E0247/E0248 (non-standard transfer benches) or with E0240 (non-standard bath/shower chairs).	Append to E0247 or E0248 for non-standard bathtub or combination bath/commode transfer benches or to E0240 for non-standard bath/shower chairs for prior authorization and manual pricing. Refer to the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule and the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)
U4	Pediatric supply item	Use with HCPCS codes listed on the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule that list the U4 modifier for pediatric pricing only. This information may also be found in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

7.7 Evaluation and Management (E/M) Services

Modifier	Description	Special Instructions
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E/M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E/M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E/M services to be paid without review. Subject to post payment audit.

Modifier	Description	Special Instructions
57	Decision for Surgery	Required for an E/M service provided the day of or the day before a procedure with a 90-day global period to indicate that the service was for the decision to perform the procedure.
UA	Admitted or transferred to inpatient hospital	Required for ED case rate paid to attending ED physician when beneficiary is admitted or transferred from the ED to the inpatient hospital.
UD	Released/Discharged from Emergency Department	Required for ED case rate paid to attending ED physician when beneficiary is treated and released/discharged from the ED.

7.8 LABORATORY

Modifier	Description	Special Instructions
90	Reference Lab	Identifies that services were referred to specialty lab. The NPI number of the reference lab must be included.
91	Repeat Clinical Diagnostic Laboratory Test	Use to identify a medically necessary repeat test done on same date.
QW	CLIA waived test	Identifies CLIA waived tests as required.

7.9 MEDICARE

Any service reported to Medicaid for a Medicare/Medicaid eligible beneficiary that is an excluded or noncovered Medicare benefit must be identified with modifier GY or GZ on the service line.

Modifier	Description	Special Instructions
GY	Excluded Medicare Benefit	Report this modifier to identify services that are excluded from Medicare coverage.
GZ	Medicare denied as not reasonable or necessary	Report this modifier to identify services determined not reasonable or necessary by Medicare.

7.10 Preventive Services

Modifier	Description	Special Instructions
33	Preventive Services	When the primary purpose of the service is delivery of an evidence-based service in accordance with a United States Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services mandates (legislative or regulatory), the service may be identified by adding modifier 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

7.11 Private Duty Nursing

Modifier	Description	Special Instructions
TT	Individualized service provided to more than one patient in same setting	Use this modifier with HCPCS code T1000 and either modifier TD for RN or TE for LPN when private duty nursing services are being provided to more than one beneficiary at one time.

7.12 Provider Preventable Conditions (PPCs)

Any service reported to Medicaid for a PPC that has been identified for non-payment must be submitted with the appropriate modifier on the service line.

Modifier	Description	Special Instructions
PA	Surgery Wrong Body Part	Use this modifier to report that service is for surgery on wrong body part
PB	Surgery Wrong Patient	Use this modifier to report that service is for surgery on wrong patient
PC	Wrong Surgery on Patient	Use this modifier to report that service is for wrong surgery on patient

7.13 School Services Program

Modifier	Description	Special Instructions
HT	Multi-disciplinary team	Use this modifier with the appropriate evaluation procedure codes to identify participation by each qualified profession in the Individuals with Disabilities Education Act (IDEA) assessment.
TL	Re-evaluation of Existing Data (REED)	Use this modifier with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.

Modifier	Description	Special Instructions
TM	Individualized Education Program (IEP)	Use this modifier with the appropriate procedure codes to identify participation by each qualified staff in the development, review and revision of the IEP.

7.14 Surgical Assistance

Modifier	Description	Special Instructions
80	Assistant Surgeon	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, XE, XP, XS, XU, the claim is not paid.
82	Assistant Surgeon (when qualified resident surgeon not available)	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, XE, XP, XS, XU, the claim is not paid.
AS	PA, NP, CNS, or CNM services for assistant at surgery	Reimbursement for services adjusted to CMS limits for reimbursement for these practitioners.

7.15 Surgical Services

Modifier	Description	Special Instructions
50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement. Refer to the Maternity Care Services section of this chapter for maternity care component billing instructions. Do not use for E/M services. Follow current CPT guidelines to determine the appropriate code to use for services performed.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10- or 90-day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement is reduced to the surgical care rate only.

Modifier	Description	Special Instructions
55	Postoperative Management Only	Reported by the physician furnishing post-op management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in Box 19.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat Procedure by Same Physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.
79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate, allows payment for services during the postoperative period unrelated to the original surgery.
FT	Unrelated evaluation and management (E/M) visit during a post-operative period, or on the same day as a procedure or another E/M visit.	Report for critical care visits that are unrelated to the surgical procedure and performed post-operatively.
XE	Separate Encounter; a service that is distinct because it occurred during a separate encounter.	This modifier should only be used to describe separate encounters on the same date of service. May be used in lieu of modifier 59 where this description provides greater specificity.
XP	Separate Practitioner; a service that is distinct because it was performed by a different practitioner.	May be used in lieu of modifier 59 where this description provides greater specificity.
XS	Separate Structure; a service that is distinct because it was performed on a separate organ/structure.	May be used in lieu of modifier 59 where this description provides greater specificity.

Modifier	Description	Special Instructions
XU	Unusual Non-Overlapping Service; the use of a service that is distinct because it does not overlap usual components of the main service.	May be used in lieu of modifier 59 where this description provides greater specificity.

7.16 Therapy Services

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. In addition, habilitative services must be reported with the appropriate modifier that represents the nature of therapy being performed. Maintenance therapy visit claims should also include the MDHHS designated maintenance modifier. Therapy services submitted without these modifiers may be denied.

Modifier	Description	Special Instructions
96	Habilitative Service	Used to identify therapy services habilitative in nature.
97	Rehabilitative Service	Used to identify therapy services rehabilitative in nature.
GP	Service delivered under an outpatient physical therapy plan of care.	Identifies services provided under a physical therapy treatment plan.
GO	Service delivered under an outpatient occupational therapy plan of care.	Identifies services provided under an occupational therapy treatment plan.
GN	Service delivered under an outpatient speech-language pathology plan of care.	Identifies services provided under a speech therapy treatment plan.
TS	Follow-up Service	Used to identify therapy services as maintenance related.

7.17 Vision

Modifier	Description	Special Instructions
U1	Polycarbonate lenses	Determines payment rate to contractor.
U2	High index lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.
55	Postoperative management only	Reported by an optometrist (with Therapeutic Pharmaceutical Agent (TPA) certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.

SECTION 8 - REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A Remittance Advice (RA) is issued with each payment to explain the payment made for each claim. If no payment is due or claims have rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for website information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment;
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or

change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.

For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.3 Paper Remittance Advice

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

8.4 Gross Adjustments

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on your RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used and defined in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

8.5 Claim Adjustment Reason/Remark Codes

When a claim is initially processed the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits which apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definition of the codes to determine the reason for the rejection.

SECTION 9 - JULIAN CALENDAR

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	- -	88	119	149	180	210	241	272	302	333	363
30	30	- -	89	120	150	181	211	242	273	303	334	364
31	31	- -	90	- - -	151	- - -	212	243	- - -	304	- - -	365

For leap year, one day must be added to the number of days after February 28. The next three leap years are 2028, 2032 and 2036.

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).

ELECTRONIC VISIT VERIFICATION

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SECTION 1 - INTRODUCTION

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan.

EVV is a technology-based validation of PCS or HHCS that is required when a provider begins or ends a visit in the home. This information helps to ensure that beneficiaries receive their authorized care. The requirement of EVV does not prohibit PCS being delivered outside of the beneficiary's home. PCS should be delivered in accordance with the beneficiary's needs, the individual plan of care, and the State Plan or Home and Community Based Service standards.

Beginning April 1, 2024, MDHHS requires the use of EVV for HHCS for Medicaid Fee-for-Service (FFS) providers serving Medicaid beneficiaries. Beginning July 1, 2024, Home Help Agency Providers are required to use EVV for Home Help beneficiaries. As of September 3, 2024, Medicaid Managed Care (Medicaid Health Plan) HHCS and PCS provided through Behavioral Health, MI Choice, MI Health Link, and Home Help Individual Caregivers are required to use EVV.

SECTION 2 – EVV INFORMATION

2.1 EVV OPEN VENDOR MODEL

MDHHS uses an open vendor EVV model. This allows providers flexibility to use the State EVV system at no cost or another EVV system of their choosing that meets State requirements. The State selected HHAeXchange as its EVV vendor and aggregator. To use an EVV system other than HHAeXchange, an agency provider must ensure compatibility with the HHAeXchange Electronic Data Interchange (EDI) process and must submit EVV information to the State's aggregator. An agency provider's use of an alternative EVV system is at their own cost.

Additional information about use of an alternative EVV system and the EDI process can be found on the HHAeXchange website. (Refer to the Directory Appendix for vendor information.)

2.2 EVV DATA REQUIREMENTS

The Cures Act requires the following six data elements to be collected for EVV:

- Type of service performed
- Name of person receiving the service
- Date of the service
- Location of the service
- Name of person providing the service
- Times the service begins and ends

2.3 EVV DATA COLLECTION METHODS

If using the State-offered EVV solution, the methods for reporting information include:

2.3.A. MOBILE APPLICATION

The mobile application can be downloaded to a caregiver-owned or employer-issued smart phone or global positioning service (GPS)-enabled tablet. The caregiver will use the device to clock-in at the start of the service and clock-out at the end of the service. This is the preferred method for reporting EVV information.

The mobile device also has an offline EVV feature that allows the caregiver to clock-in and clock-out while offline, as in the absence or loss of an internet connection. The information will transmit the stored data once internet connection returns. The data is time-sensitive, requiring the caregiver to ensure access to an internet connection within seven calendar days of service delivery.

2.3.B. Interactive Voice Response (IVR)/Telephony

Using the beneficiary's landline, the caregiver will call into a designated toll-free EVV telephone line to clock-in at the start of the service and place a second call to clock-out at the end of the service. This is an approved method of reporting EVV, but only expected to be used if the mobile application is not an option.

A caregiver may use IVR when:

- The beneficiary authorizes the use of their landline for EVV.
- The beneficiary's services start and end in their home.

If the beneficiary does not have a landline that can be used for the purpose of EVV, the caregiver must use the mobile application. Agency providers must ensure caregivers have access to alternate methods to capture EVV data.

If using an alternative EVV vendor system, caregivers will use their vendor's existing data collection methods, as long as the system has been validated as meeting federal and state EVV requirements. Refer to the HHAeXchange website for additional information about validation of an alternative EVV system. (Refer to the Directory Appendix for vendor information.)

2.4 Alternative EVV Vendor

If using an alternative EVV vendor system, providers will use their vendor's existing data collection methods, as long as the system has been validated as meeting federal and state EVV requirements.

SECTION 3 – PERSONAL CARE SERVICES

3.1 PCS SERVICE CODES

The Michigan Medicaid program covers PCS that are provided under the State Plan and waivers of the State Plan. The following procedure codes, listed by program, require the use of EVV. Any PCS listed below that starts or ends in the beneficiary's home requires EVV.

Program	Procedure Code	Service Description
Behavioral Health	H2015	Community Living Supports (CLS)
	T1005	Respite Care, per 15 minutes
Home Help	T1019: CG	Personal Care Services
MI Choice	H2015	Comprehensive Community Support Services, per 15 minutes
	S5150	Unskilled Respite Care, not Hospice, per 15 minutes
MI Health Link	H2015	Comprehensive Community Support Services, per 15 minutes
	S5150	Unskilled Respite Care, not Hospice, per 15 minutes
	T1019	Personal Care Services (PCS), per 15 minutes

NOTE: PCS provided through Community Transition Services are excluded from EVV.

Home Help providers must use their current service verification methods (i.e., Community Health Automated Medicaid Processing System [CHAMPS] Electronic Service Verification, Paper Service Verification or the MSA-1904 Home Help Agency Invoice). Payments will be based on the data recorded on the current service verification methods.

3.2 EVV PCS EXCLUSIONS

The following sections contain information on congregate living settings, live-in caregivers, and beneficiaries who receive PCS through Home Help and Behavioral Health services during the same visit. PCS provided to beneficiaries who live in these settings, live with their caregiver(s), or receive Home Help and Behavioral Health services, as described below, are exempt from EVV for their PCS.

NOTE: Home Help providers who are eligible for these exemptions must document Home Help services using an alternate service verification designated by MDHHS. Additional information will be provided prior to Home Help payments being tied to EVV data.

3.2.A. BENEFICIARIES RECEIVING HOME HELP AND BEHAVIORAL HEALTH SERVICES

Beneficiaries who receive PCS through both Home Help and Behavioral Health in the same visit rendered by the same caregiver are excluded from EVV. When only one of these program's (Home Help OR Behavioral Health) services is rendered during a visit, EVV must be used.

3.2.B. Congregate Living

The Centers for Medicare & Medicaid Services (CMS) does not require EVV for PCS provided in settings offering 24-hour service availability or in congregate residential settings where 24-hour service is available. There are inherent differences in service delivery models where an employee of a congregate residential setting furnishes services to multiple individuals throughout a shift (this example would NOT require EVV), and for services provided to an individual during an in-home "visit" where the provider goes to a private home or congregate residential setting to provide PCS (this example DOES require EVV), as specified in the EVV statute.

Congregate residential settings that provide PCS that do not require EVV include:

- Adult Foster Care Homes;
- Child Foster Care Homes;
- Homes for the Aged;
- Licensed Respite; and
- Residential settings (including unlicensed provider-owned and/or -operated and privately-owned/-leased settings) with 24 hours per day/7 days per week service availability to two or more unrelated individuals throughout a shift.
  - Home Help services provided in room and board settings do not qualify for the congregate living exemption.

3.2.C. Live-In Caregivers

For the purposes of EVV, the definition of "live-in caregiver" requires the provider to meet all the following criteria:

- The caregiver lives in the same home as the beneficiary;
- The home is the caregiver's permanent and primary residence; and
- The caregiver is responsible for providing PCS that require EVV to the beneficiary.

The caregiver could be employed by the beneficiary, through a home care agency, or through an approved self-determination arrangement.

Live-in caregiver exemptions must be approved by MDHHS or an Approving Entity using the process detailed below. An "Approving Entity" is designated by MDHHS but is not an agency provider.

Approving entities are defined as follows:

Program	Approving Entity
Behavioral Health	Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program (CMHSP) designee
Home Help	MDHHS Adult Services Worker
MI Choice Waiver	MI Choice Waiver Agencies
MI Health Link	Integrated Care Organization (ICO) or designee

Live-in caregivers who do not complete all requirements for the exemption process must use EVV. Those caregivers with a pending exemption request must use EVV until their exemption request has been approved. Live-in caregivers must adhere to outlined policy to continue to be exempt from reporting EVV.

Live-in caregivers paid through a provider agency (i.e., home care agency, fiscal intermediary, etc.) may be required to use an EVV system for business purposes, such as service verification and payroll. The live-in caregiver exemption does not prevent an agency from requiring their caregivers to use EVV for business purposes.

3.2.C.1. Exemption Process for Live-In Caregivers

The live-in caregiver must complete form BPHASA-2421, Live-In Caregiver Attestation and provide two of the following as proof of residency. (Refer to the Forms Appendix for a copy of the form. The form is also available on the MDHHS website; refer to the Directory Appendix for website information.) Documents must include the live-in caregiver's name and current home address. Electronic copies of the following are accepted.

- Valid Michigan driver's license
- Valid Michigan state identification
- Utility bill or credit card bill issued within the last 90 days
- Account statement from a bank or other financial institution issued within the last 90 days
- Mortgage, lease or rental agreement (lease and rental agreements must include the landlord's telephone number)
- Pay stub or earnings statement issued within the last 90 days
- Life, health, auto or home insurance policy
- Michigan vehicle title and registration
- Federal, state or local government documents, such as receipts, licenses or assessments

BPHASA-2421 includes space for the caregiver to enter their CHAMPS Provider ID Number. For programs other than Home Help, caregivers may not have a CHAMPS

Provider ID. Caregivers without a CHAMPS Provider ID may leave this field blank or write "N/A" in the field.

The live-in caregiver must submit BPHASA-2421 to the correct Approving Entity. A completed BPHASA-2421 should be submitted directly to the Approving Entity; however, it may be submitted to the provider agency employer or fiscal intermediary (FI) who will forward it to the Approving Entity according to their records.

Renewal of live-in status must be done at least annually and any time the beneficiary's or caregiver's address changes. For the annual renewal, if the beneficiary and caregiver address remains the same, the caregiver signs a new BPHASA-2421, Live-In Caregiver Attestation, for the MDHHS representative or Approving Entity to approve. No additional documentation is required.

A new BPHASA-2421 must be obtained if the beneficiary and live-in caregiver move to a new address. When the caregiver no longer lives with the beneficiary, the caregiver must report this to their MDHHS representative, the fiscal intermediary, home care agency or Approving Entity within ten calendar days. If this caregiver is still providing services that require EVV, the EVV system must be used immediately upon moving out of the shared residence. When the home care agency or fiscal intermediary finds that the caregiver no longer lives with the beneficiary, they must notify MDHHS or the Approving Entity within three business days.

3.2.C.2. Responsibilities of Approving Entities and Other Parties Related to Live-In Caregiver Exemption Process

The MDHHS representative and Approving Entity are responsible for:

- Approval or denial of the individual as a live-in caregiver;
- Providing to the caregiver a reason for denial, if applicable;
- Signing the BPHASA-2421, Live-In Caregiver Attestation;
- Retaining the signed BPHASA-2421 in the beneficiary's case record;
- Sending a copy of the approved BPHASA-2421 to the beneficiary, the live-in caregiver, and the fiscal intermediary or home care agency;
- Updating live-in caregiver information in the EVV system; and
- Monitoring live-in caregiver compliance to live-in caregiver policy.

The MDHHS representative or Approving Entity must review the BPHASA-2421 and documents and provide to the caregiver a reviewed, signed BPHASA-2421 within ten business days of the approver's receipt. Caregivers with a denied request may resubmit a corrected form, as applicable.

Each program's Approving Entity must establish a standard process for submission and review of the BPHASA-2421 and documentation. This process must include a secure process for receiving the documentation if email is used so that personal identifying/health information is not shared publicly.

The Approving Entity is required to have at least two designated approvers (a primary approver and a backup approver) so that review of the form is not delayed if an approver is unavailable. The Approving Entity must review BPHASA-2421 and attached documents and make the decision to approve or deny the exemption request within ten (10) calendar days of receipt of the documentation. If the request is denied, the Approving Entity must indicate a Reason for Denial on BPHASA-2421. The reason for denial must be detailed so the caregiver understands why it is denied.

The Approving Entity must share the approved or denied BPHASA-2421 with the provider agency or FI, live-in caregiver, and the beneficiary. Caregivers must use EVV until an approval is received. NOTE: Home Help caregivers who have submitted the BPHASA-2421 to their Home Help client's MDHHS adult services worker (ASW) are exempt from using EVV until a determination is made.

Provider agencies are required to complete initial set-up within the HHAeXchange system that reflects the beneficiary has an approved live-in caregiver exemption. This requires the provider agency or FI (depending on system access allowed) to enter the live-in caregiver as a "Residing Caregiver" in the appropriate field in the HHAeXchange system. This step will support pre- and post-payment reconciliation needs.

The Approving Entity is required to ensure that documentation is maintained in accordance with their program's document retention policies and must be shared with MDHHS upon request for audit or monitoring purposes.

If the beneficiary transfers to a different Approving Entity, the receiving Approving Entity must maintain the BPHASA-2421 and documentation and may choose to adopt the current BPHASA-2421 or obtain a new one.

3.2.C.3. Renewal of Live-in Caregiver Status for Managed Care Programs

Renewal of live-in status must be done annually. Using the Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation letter template, the Approving Entity must notify the caregiver of the upcoming end date (one year after the signed BPHASA-2421) of their approved BPHASA-2421 so the caregiver can timely submit the annual renewal documentation. This notifying letter should be sent to the caregiver, provider agency or FI, and beneficiary. The Approving Entity may send BPHASA-2421 with this letter for the caregiver to use for their renewal. The Managed Care Program Approving Entity must send notification at least 30 calendar days prior to the end date of the existing Attestation. (Refer to the Forms Appendix of this manual for the Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation letter.)

If the caregiver fails to submit renewal documentation, this must not delay services. The caregiver would no longer be exempt from using EVV and would have 30 days to get set-up with EVV. If EVV is not used after the 30-day grace period, the Approving Entity is held responsible for non-compliance and potential recoupment of funds.

If a beneficiary moves with a caregiver, and the caregiver does not notify the Approving Entity within ten (10) calendar days, the Approving Entity must provide notice that the

current BPHASA-2421 will end and on what date. The caregiver will have 30 calendar days from this notice to submit a new BPHASA-2421 and documentation to maintain the live-in caregiver exemption. If documentation is not provided, the caregiver must begin using EVV. The EVV set-up will occur within that 30-day period after the Approving Entity is notified of the move. During the transition/move, a United States Postal Service (USPS)-issued Change of Address form or Michigan Secretary of State issued temporary State ID are acceptable forms of documentation.

If a provider has recurring issues with non-compliance, the Approving Entity must address the issues with the provider. The Approving Entity must allow time for the provider to make corrections.

3.2.C.4. Renewal of Live-in Caregiver Status for the Home Help Program

Renewal of live-in status must be done every six months to remain exempt from EVV. ASWs will work with caregivers to complete a renewal of BPHASA-2421 during each six-month review.

3.3 PCS Provider Enrollment

Providers who render/bill PCS to Medicaid beneficiaries are required to be enrolled in the Medicaid program and uniquely identified on claims to be eligible for reimbursement. The chart below, titled Provider Enrollment Requirements, identifies all EVV PCS provider enrollment requirements.

Provider Enrollment Requirements

Program	Provider	Requires an NPI?	Requires enrollment in CHAMPS?
Behavioral Health	Agency Provider	**YES**	**YES**
	Fiscal Intermediary	**YES**	**YES**
	Individual Provider/ Direct Care Worker	No	No
Home Help	Agency Provider	**YES**	**YES**
	Individual and Agency Caregivers	No	**YES**
MI Choice	Agency Provider	**YES**	**YES**
	Fiscal Intermediary	**YES**	**YES**
	Individual Provider/ Direct Care Worker	No	No
MI Health Link	Agency Provider	**YES**	**YES**
	Fiscal Intermediary	**YES**	**YES**
	Individual Provider/ Direct Care Worker	No	No

To obtain an NPI, providers must complete the online application at the National Plan and Provider Enumeration System (NPPES) website. (Refer to the Directory Appendix for website information.) Providers must enroll as a Type 2 (Organization) NPI.

To enroll as a Medicaid provider, the provider must complete an online application in CHAMPS and, if required, enroll with a Type 2 (Organization) NPI. To access CHAMPS, providers must register for a MILogin User ID and password. (Refer to the Directory Appendix for website information.)

Providers must enroll in CHAMPS under the following Enrollment Type, Provider Name, Specialty, and Subspecialty, depending on their provider type and the services they are providing/billing. Providers who have multiple specialties or subspecialties may select as many as applicable.

Provider	Program	Enrollment Type	Provider Name	Specialty	Subspecialty
Individual	Home Help	Atypical	Atypical Individual	Home Help (Individual)	No Subspecialty
Agency	Home Help	Atypical	Atypical Agency	Home Help Facility/ Agency/ Organization (FAO)	No Subspecialty
	Behavioral Health MI Choice MI Health Link			Home and Community Based Services Agencies	Community Living Supports
					Expanded Community Living Supports
					Personal Care Services
					Respite
Fiscal Intermediary	Behavioral Health MI Choice MI Health Link	Atypical		Fiscal Intermediary	Community Living Supports
					Expanded Community Living Supports
					Personal Care Services
					Respite

An approved provider enrollment application in CHAMPS and an NPI (if required) are necessary for the EVV system to track services and payments for agencies and fiscal intermediaries. Claims submitted with dates of service prior to provider enrollment approval will be rejected.

Providers must meet the requirements in the Provider Enrollment Requirements chart above prior to using EVV.

Refer to the General Information for Providers chapter of this Manual for information about provider enrollment procedures and regulations.

SECTION 4 – HOME HEALTH CARE SERVICES

4.1 HOME HEALTH CARE SERVICE CODES

The following HHCS codes require EVV:

- G0151 - Physical Therapy
- G0152 - Occupational Therapy
- G0153 - Speech/Language Therapy
- G0156 - Home Health Aide
- G0299 - Skilled Nursing Services, RN
- G0300 - Skilled Nursing Services, LPN

The EVV-required codes for HHCS are listed on the Home Health billing and reimbursement website. (Refer to the Directory Appendix for website information.)

4.2 EVV HOME HEALTH CARE SERVICE EXCLUSIONS

The following HHCS are excluded from EVV:

- Hospice Services
- Durable Medical Equipment (DME) Services
- HHCS visits for beneficiaries who are dually enrolled with Medicare and Medicaid are excluded from EVV requirements. Providers are not required to collect EVV data for HHCS visits for these beneficiaries.

SECTION 5 – EVV COMPLIANCE

Programs that require the use of EVV for their HHCS or PCS must be compliant with the EVV policies within this chapter. Failure to comply with these requirements may result in non-payment of Medicaid services.

AMBULANCE

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SECTION 1 - INTRODUCTION

1.1 GENERAL INFORMATION

This chapter applies to Ambulance providers and Hospital-Owned Ambulance Services.

The Michigan Department of Health and Human Services (MDHHS), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate, regardless of whether there is a corresponding medical claim on the date of service, when:

- Medical/surgical or psychiatric emergencies exist; or
- No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Services that have been excluded from direct reimbursement to ambulance providers are:

- Services that are not medically necessary.
- Services that are included as a part of the base rate.
- Services for beneficiaries in a nursing facility (NF) that are reimbursed as part of the facility's per diem or are billed separately by the facility.
- Services reimbursed as part of the Diagnosis Related Groups (DRG) rate for beneficiaries who are inpatients at a hospital, are sent to another facility for services, and returned to the originating hospital without being discharged from the originating hospital.
- Services to Medicaid Health Plan (MHP) enrollees.
- Nonambulance, non-emergency medical transportation that is provided by a MHP.
- Nonambulance, non-emergency medical transportation arranged by either the local MDHHS office or an MDHHS-contracted transportation broker who reimburses the beneficiary or the transportation provider directly.

The Covered Services Section of this chapter describes the coverages and limitations for payment of ambulance services by Medicaid.

Special billing instructions follow coverage sections, where applicable. These instructions assist the ambulance provider in obtaining reimbursement and must be used in conjunction with the completion instructions found in the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers chapters of this manual and the Healthcare Common Procedure Coding System (HCPCS) manual.

1.2 Common Terms

The following terms have specific meanings in the Ambulance Program:

Advanced Life Support (ALS) Assessment	An assessment performed by an ALS crew (minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic) as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment to determine whether the patient's condition requires an ALS level of care. The completion of an ALS assessment does not necessarily result in a determination that the patient requires an ALS intervention.
Advanced Life Support Intervention	A procedure in accordance with state and local laws that is required to be performed by minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic.
Ambulance	A motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.
Base Rate	A payment rate associated with the level of service provided. Included in the base rate is oxygen, equipment and supplies essential to the provision of services, and accompanying personnel.
Continuous or Round Trip	An ambulance service in which the patient is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the beneficiary is then transported to a more appropriate facility for care or back to the place of origin.
Emergency Medical Technician (EMT)	An individual licensed by the state of Michigan to provide BLS services.
Emergency Medical Technician Specialist (EMT-S)	An individual licensed by the state of Michigan to provide limited ALS services.
Emergency Response	A response that, at the time the ambulance provider is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that in the absence of immediate medical attention could reasonably be expected to result in: ▪ placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or their unborn child) in serious jeopardy, ▪ serious impairment to bodily functions, or ▪ serious dysfunction to any bodily organ or part.
Fixed Wing Air Ambulance	An aircraft, such as an airplane, that is licensed as a fixed wing air ambulance and such ancillary services as may be medically necessary.
Loaded Mileage	The number of miles for which the Medicaid beneficiary is transported in the ambulance vehicle.
Medically Necessary Transport	An ambulance transport which is required because no other effective and less costly mode of transportation can be used due to the patient's medical condition.
Neonate	An infant less than four weeks old.

Neonate Return Transfer	An ambulance transport that returns a stabilized neonate from a Level III or Level IV NICU back to the Level I Well Born Nursery or Level II Special Care Nursery from which the neonate was originally transferred.
Neonatal Transport Team	A team of experienced, specialized, multidisciplinary health care providers (established and defined by a health care facility) who are trained for, and immediately available to respond to, calls for high risk neonatal transports.
Paramedic	An individual licensed by the state of Michigan to provide ALS services.
Rotary Wing Air Ambulance	An aircraft, such as a helicopter**,** that is licensed as a rotary wing air ambulance and such ancillary services as may be medically necessary.
Transfer	The movement of a beneficiary from one health care facility to another in a licensed ground or air ambulance because a medically necessary service was not available at the primary location.
Waiting Time	When an ambulance provider waits at a hospital while a beneficiary is being stabilized, with the intent of continuing transport to a more appropriate hospital for care, or back to the beneficiary's point of origin.

1.3 Ambulance Services

MDHHS recognizes different levels of medical services provided by qualified ambulance staff according to the standards established by law and regulation through Michigan Public Act 368 of 1978 as amended. The standards established for each level of service are detailed in the Base Rate subsection of this chapter.

The beneficiary's attending physician must order all non-emergency, medically necessary ambulance transportation. The ambulance provider must retain all documentation supporting the nature of the service in the beneficiary's file regardless of the level of service provided. (Refer to the Emergency and Non-emergency subsections of this chapter for additional information.)

1.4 Medical Necessity

Medical necessity is established when the beneficiary's condition is such that use of any other method of transportation is contraindicated. In cases where a mode of transportation other than an ambulance could be used without endangering the beneficiary's health, no payment may be made for ambulance services regardless of whether such other transportation is available.

The medical care personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and Medicaid guidelines. Medical necessity for non-emergency transports must be substantiated with a physician's written order. Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file.

1.5 Documentation Requirements

Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file. This documentation may be used to assess whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. Documentation must be sufficiently detailed to allow reconstruction of what transpired for each service

billed. (Refer to the General Information for Providers chapter of this manual for information on documentation.) The level of service and assessment findings must be fully documented. An ambulance provider must document the medical necessity and clinical significance of an ALS assessment in the beneficiary's file. The ambulance service must meet all program coverage criteria for payment to be made.

1.6 Diagnosis Codes

Providers must enter the appropriate ICD diagnosis code on all ambulance claims. Providers must report the most specific diagnosis code available that identifies the reason for the service. When billing for emergency transports, refer to the Covered Services Section, Emergency subsection of this chapter. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

Documentation supporting the diagnosis code must be retained in the ambulance provider's records for audit purposes.

1.7 Usual and Customary Charges

Providers must bill MDHHS the usual and customary (U&C) fee charged to the public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. If one charge is made to tax-paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.

Refer to the Billing & Reimbursement for Professionals, the Billing & Reimbursement for Institutional Providers, and the Coordination of Benefits chapters of this manual when the beneficiary also has Medicare or other insurance.

1.8 Medicare/Medicaid Coverage

MDHHS reimburses the ambulance provider for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on Medicare approved claims, even if Medicaid does not normally cover the service.

Refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapter of this manual, as appropriate, for instructions on completing the claim after Medicare has approved the services.

1.9 Prior Authorization

For services requiring PA, the ambulance provider must request authorization from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.) The request must include the following information:

- Beneficiary's name and Medicaid ID number

- Diagnosis
- Point of pick-up and destination
- Services(s) to be provided
- Explanation as to why the ambulance transportation is medically necessary
- Explanation as to why the beneficiary cannot be transported by other means
- Name, address, and National Provider Identifier (NPI) of the ambulance provider
- PA requestor's name

Based on the documentation provided, PRD approves or denies the PA request. The ambulance provider may not bill MDHHS for prior authorized services until PRD approves the PA request. The PA requestor must notify PRD of any changes made to the approved authorization. Except as otherwise specified, the PA number must be entered on the claim before the ambulance provider is reimbursed for services.

SECTION 2 - COVERED SERVICES

2.1 AIR AMBULANCE

Air ambulance providers who are licensed by MDHHS to provide emergency medical services and are properly enrolled in the Medicaid program may be reimbursed for medically necessary air ambulance services. To become Medicaid-enrolled, Michigan-licensed air ambulance providers must submit a copy of their state-issued aircraft operations license number with their provider enrollment application. For prospective air ambulance providers who are not Michigan-licensed, a copy of their respective state-issued aircraft operations license must be submitted with their provider enrollment application, along with a copy of their Commission on Accreditation of Medical Transport Systems (CAMTS) accreditation or an affidavit of substantial CAMTS accreditation compliance. Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or rotary wing air ambulance status. Coverage of the air ambulance services includes the base rate, loaded mileage, and waiting time.

Medicaid reimburses air ambulance services only when a beneficiary requires medical or surgical (not diagnostic) procedures, and their condition requires rapid transportation to a treatment facility. One of the following requirements must be met:

- Great distance or obstacles preclude such delivery to the most appropriate facility; or,
- The beneficiary is inaccessible by either ground or water ambulance.

Hospital-to-hospital emergent transfers performed by either a rotary wing or fixed-wing air ambulance require clinical documentation (i.e., the History and Physical [H & P] report) from the beneficiary's attending physician validating the need for the air, rather than ground, transportation. (Refer to the Emergency subsection of this chapter for more information on emergent transports.)

The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.

Non-emergent air ambulance transports require an order from the beneficiary's attending physician and must be prior authorized. (Refer to the Ambulance Services subsection of this chapter for documentation requirements for emergency and medically necessary services.)

The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.

2.1.A. FIXED WING AIR AMBULANCE

The Medicaid Provider Enrollment file reflects enrollment as a fixed wing air ambulance provider.

2.1.B. Rotary Wing Air Ambulance

The Medicaid Provider Enrollment file reflects enrollment as a rotary wing air ambulance provider.

2.2 Base Rate

The ambulance provider may bill one base rate procedure code:

- Advanced Life Support 1 (ALS 1) Non-emergency;
- ALS 1 Emergency;
- Advanced Life Support 2 (ALS 2);
- Basic Life Support (BLS) Non-emergency;
- BLS Emergency;
- Neonatal Emergency Transport;
- Rotary Wing Air Ambulance; or
- Fixed Wing Air Ambulance Transport.

The determination to respond emergently with either an ALS or BLS ambulance vehicle is dependent upon local 911 or equivalent service dispatch protocol. Where the dispatch was inconsistent with this standard of protocol, or where no protocol was used, the beneficiary's condition at the time of ambulance arrival determines the appropriate level of reimbursement. Even if a local government or medical control authority requires an ALS response to all calls, the base rate billed must reflect the level of service rendered and not the type of vehicle in which the beneficiary was transported. Medicaid will only pay for the level of service required and provided.

Reimbursement for the base rate covers all services rendered except mileage that may be billed separately.

When treatment is rendered and no other care or transport is necessary, ambulance providers may bill the base rate procedure code for the level of service performed but not for mileage. (Refer to the Special Situations Section of this chapter for instructions regarding intercept situations.)

2.3 Advanced Life Support

Ambulance operations and ambulance staff must be licensed to render advanced life support (ALS) services by the State and properly enrolled with MDHHS.

2.3.A. Advanced Life Support, Level 1 (ALS1) – Non-emergency

ALS1 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, which includes an ALS assessment or the furnishing of at least one ALS intervention within the context of a non-emergency response.

Ambulance providers must secure a physician's written order indicating the medical necessity of the elevated level of transport and retain it in their files. (Refer to the Non-emergency subsection of this chapter for additional information.)

2.3.B. Advanced Life Support, Emergency Transport, Level 1 (ALS1) – Emergency

ALS1 is defined as the transportation by ground ambulance and the provision of ALS1 services within the context of an emergency response. The furnishing of an ALS assessment, without a medically necessary ALS intervention, is sufficient to bill the ALS base rate if the beneficiary's condition at the time of dispatch indicated an ALS level of service was required, provided that ambulance transportation itself was medically reasonable and necessary.

2.3.C. Advanced Life Support, Level 2 (ALS2)

ALS2 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including an ALS assessment, and:

- at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusions (excluding crystalloid fluids); or
- one or more of the following ALS2 procedures:
  - Manual defibrillation/cardioversion
  - Endotracheal intubation, or the monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport
  - Central venous line
  - Cardiac pacing
  - Chest decompression
  - Surgical airway
  - Intraosseous line

Reimbursement for the ALS base rates includes those services listed under BLS and is the same whether or not special services were performed.

2.4 Basic Life Support

Ambulance operations and ambulance staff must be licensed to render BLS services by the State of Michigan) and properly enrolled with MDHHS. Medicaid coverage of the BLS base rate includes transportation and medical services that an EMT is routinely trained to provide (e.g., the provision of oxygen and resuscitation). Reimbursement for accompanying personnel, suctioning, labor/delivery, emergency first aid, emergency/night call services, oxygen, and resuscitation is included in the BLS base rate.

BLS also includes equipment and supplies essential to providing such services (e.g., splints, backboards, obstetrical kits).

2.4.A. Basic Life Support (BLS) – Non-emergency

BLS – Non-emergency is defined as the transportation by ground ambulance as defined above within the context of a non-emergency response. The BLS service must be provided by either a BLS or an ALS licensed provider.

Ambulance providers must secure a physician's written order indicating the medical necessity of the transport and retain it in their files. (Refer to the Non-emergency subsection of this chapter for additional information.)

2.4.B. Basic Life Support (BLS) – Emergency

BLS is defined as the transportation by ground ambulance and when either a BLS or an ALS licensed provider renders BLS services as defined above within the context of an emergency response.

2.5 Drugs and Solutions

Drugs, intravenous solutions and needles, and syringes and hypodermic needles carried in ambulances require replacement by a cooperating hospital pharmacy and under the supervision of a licensed pharmacist. Only the hospital is reimbursed for these items.

2.6 Emergency

Claims may be made to MDHHS for emergency transports that meet the criteria specified in the definitions of BLS Emergency, ALS 1 Emergency and ALS 2 transports in this section.

Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to a hospital, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.

To assure appropriate coverage and reimbursement for emergency ambulance services, MDHHS maintains a list of diagnosis codes for emergency ambulance transport. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

2.7 Mileage

Mileage reimbursement is a Medicaid benefit when:

- A transport occurs.
- Loaded mileage is billed.
- Appropriate origin and destination modifier combinations are utilized.

Ambulance mileage reimbursement is a covered Medicaid benefit when a transport occurs and has been reimbursed. Transports that are denied for any reason, including lack of emergency criteria, will also be denied for the mileage reimbursement.

Refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for a list of origin and destination modifiers.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks section.

2.8 NEONATAL

Coverage of neonatal transport includes the neonatal base rate, loaded mileage, and waiting time. The cost of the transfer isolette use is included in the neonatal base rate.

The intensive care transport of critically ill neonates to an approved, designated Level III or Level IV Neonatal Intensive Care Unit (NICU), as approved and designated by Certificate of Need (CON) review standards, is covered.

A neonatal transport team must accompany the neonate. The neonatal transport team has primary responsibility for the neonate and the hospital is reimbursed for these services. The designated ambulance provider may bill the neonatal base rate and mileage for the transport.

A neonate return transfer from a NICU to a Level I Well Newborn Nursery or a Level II Special Care Nursery (after the neonate's condition is stabilized) is covered if the transportation is ordered by the neonate's attending physician. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services subsection of this chapter.

Waiting time that exceeds 30 minutes is reimbursable and must be billed consistent with the Waiting Time subsection of this section.

2.9 NON-EMERGENCY [CHANGE MADE 4/1/2025]

A claim may be made to MDHHS for a scheduled, medically necessary non-emergency ambulance transport only when the beneficiary's attending physician orders the transportation and provides, to the ambulance provider, a written order (e.g., physician certification statement) certifying the medical necessity of the transport.

The ambulance provider must retain a copy of the physician's order in the beneficiary's file.

The written order must contain, at a minimum, the following information:

- beneficiary's name and Medicaid identification (ID) number;
- attending physician's NPI number and attending physician or provider signature;
- type of transport necessary;
- explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used);
- origin and destination;
- diagnosis;
- frequency of needed transports (required for ongoing, planned treatment);

- type of ongoing treatment (required for ongoing, planned treatment); and
- an explanation of why ground transportation is not appropriate (required when transported by air ambulance).

A separate physician's order is required for each individual round trip transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary.

If the ambulance provider is unable to obtain a written order signed by the beneficiary's attending physician, a physician's assistant, advanced practice registered nurse (including nurse practitioner, clinical nurse specialist and certified nurse midwife), registered nurse, or discharge planner who is knowledgeable about the beneficiary's condition and who is employed by the attending physician or facility to which the beneficiary was admitted may sign in the physician's place.

The ordering provider may be held responsible if a medically unnecessary ambulance transport is ordered. The ordering provider may be subject to corrective action related to these services, including recoupment of funds. Additionally, any instances in which the ordering provider fails to document all required information necessary for a written order (e.g., physician certification statement) may be subject to recoupment of funds. The ambulance provider may be subject to corrective action, including the recoupment of funds, if it submits a claim for a medically necessary non-emergency ambulance transport without record of a written order.

Non-emergency transport in a Medi-van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from the local MDHHS office, an MDHHS contracted transportation broker or, if the beneficiary is enrolled, an MHP. Refer to the Non-Emergency Medical Transportation Chapter of this manual for additional information.

(text box was deleted per bulletin MMP 24-33)

2.10 Unlisted Ambulance Service

If a service is rendered that is not included in the coverages defined under the existing procedure codes, the ambulance provider may bill the procedure under the Unlisted Ambulance Service procedure code. The claim pends for manual review to determine whether the service is reimbursable under Medicaid guidelines.

Additional considerations:

- Items included in the base rate are not separately reimbursable.
- If no transport was provided, refer to the base rate billing instructions.
- A complete description of the service must be included in the Remarks section or as an attachment to the claim.

2.11 Waiting Time

Waiting time is covered only when the beneficiary's attending physician deems it medically necessary. Waiting time is reimbursable after the first 30 minutes.

If more than four hours of waiting time is required, providers must request individual consideration and provide documentation. Providers should refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for instructions.

2.12 Interfacility Transfers

Hospital transfers to the nearest hospital that has the necessary service may be covered when the beneficiary has been stabilized at the first hospital but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include, but are not limited to, services not available at the first facility such as rehabilitation, a burn unit, ventilator assistance, or other specialized care. The ambulance provider must maintain documentation that clearly describes what service(s) is not available at the first facility. Transport from a hospital capable of treating the beneficiary to another hospital for the convenience or preference of the ordering provider, beneficiary or beneficiary's family is not a covered benefit.

SECTION 3 - SPECIAL SITUATIONS

3.1 INTERCEPTS

In situations where a BLS vehicle intercepts with an ALS vehicle, each provider may bill for the appropriate base rate and for the loaded mileage they provided (if any).

3.2 BRIDGE/TUNNEL TOLL

Bridge and tunnel toll charges are reimbursable to the ambulance provider, both loaded and return trip.

Billing instructions:

- The Unlisted Ambulance Service code must be used.
- All toll charges must be combined on one claim line.
- The Remarks section must contain the bridge or tunnel name and the number of times used.

3.3 CONTINUOUS OR ROUND TRIP TRANSPORT

These types of transports are considered to be one run. The base rate code for the highest level of service performed during transport should be billed on one claim line. Loaded mileage is also billed on one claim line, with the total number of whole (loaded) miles indicated as the quantity.

Refer to the Waiting Time subsection of this chapter in cases where waiting time exceeds 30 minutes.

3.4 NURSING FACILITIES

When a resident requires physician ordered medically necessary non-emergency ambulance transportation, the ambulance provider may only bill MDHHS directly. This cost must not be claimed as a routine cost on Michigan's Medicaid cost report. The ambulance provider must maintain the physician's written order as documentation of medical necessity. (Refer to the Nursing Facility Coverages Chapter of this manual for additional information.)

If a resident's attending physician does not order non-emergency ambulance transport, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient-pay amount. This cost must not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of non-emergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the NF.

3.5 MULTIPLE ARRIVALS

When multiple units respond to a call for services, only the entity that actually provides services to the beneficiary may bill and be paid. The entity that rendered service/care should bill for all services furnished.

3.6 Multiple Beneficiaries Per Transport

When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half of the base rate.

Separate claims must be submitted for each beneficiary. The first claim is completed in the usual manner and the base rate billed must reflect the highest level of service performed.

Claims for additional beneficiaries must indicate the U&C base rate charge. The appropriate modifier must be reported. Providers should refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for a list of modifiers. Payment is made at 50 percent of Medicaid's reimbursement rate or 50 percent of the provider's charge (whichever is less).

No mileage or waiting time is to be charged for additional beneficiaries. These services are included in the reimbursement of the first claim.

3.7 Multiple Transports Per Beneficiary

If more than two ambulance transports are needed for the same beneficiary on the same date of service, the third transport will require PA. When additional transports of an emergent nature are necessary, ambulance providers can secure PA after the transport has been rendered. (Refer to the Prior Authorization subsection of this chapter for additional information.) Additional information regarding billing is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals Chapters of this manual.

3.8 Out of State/Beyond Borderland Transports

Except in situations when an emergency response is required, out of state/beyond borderland ambulance transports require PA. (Refer to the General Information for Providers chapter of this manual for additional information on out of state/beyond borderland policy.) (Refer to the Prior Authorization subsection of this chapter for additional information.)

3.9 Pronouncement of Death

In situations where a Medicaid beneficiary dies, reimbursement to a Medicaid ambulance provider depends upon when the beneficiary's death occurs. If a beneficiary is pronounced dead by an individual legally authorized to pronounce death:

- Prior to the time that the ambulance is called, no payment is made.
- After the ambulance is called, either before or after the ambulance arrives at the scene, payment for an ambulance trip is made at the BLS rate, but no mileage is paid.
- On arrival to the receiving hospital after getting medically necessary care during the ambulance transport from the scene to the receiving facility, payment is made at the medically necessary level of service furnished.

SECTION 4 – AMBULANCE COVERAGE EXCLUSIONS

Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to:

- Transport to services that are not Medicaid-covered.
- Transports that are not medically necessary, whether medical/surgical or psychiatric.
- Transport mileage when transports are denied for any reason, including lack of emergency criteria.
- Medi-car, Medi-van, or wheelchair transports.
- Transport to a funeral home.
- Trips made for services, such as drawing blood and catheterization that could have been provided at the beneficiary's location.
- Transportation of a beneficiary pronounced dead before the ambulance was called.
- Round trips when a beneficiary is taken from a hospital to another facility and returned to the same hospital. As long as the beneficiary is an inpatient, all ancillary services are the responsibility of the hospital.
- Transport of inmates to or from a correctional facility.

SECTION 5 – AMBULANCE QUICK REFERENCE GUIDE

Transports rendered in an emergency situation are covered in all settings. Use the following table to determine if the service is covered, not covered or if covered but to be billed to another facility/entity.

	To Inpatient	To Emergency Department Outpatient	To Nursing Facility	To Ambulatory Setting (i.e., Lab, Office, Clinic, Therapy, Dialysis)	To Home
From Inpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Emergency Department Outpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Nursing Facility	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Ambulatory Setting (i.e., lab, office, clinic, therapy, dialysis)	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Home	Emergency Only	Emergency Only	If Medically Necessary	If Medically Necessary	Not Covered
From At Large (Example: Scene of accident)	Emergency Only	Emergency Only	Not Covered	Emergency Only	Not Covered

AMBULATORY SURGICAL CENTERS

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SECTION 1 - INTRODUCTION

Pursuant to Section 1642 of Public Act 131 of 2009, Michigan Department of Health and Human Services (MDHHS) recognizes and reimburses Ambulatory Surgical Center (ASC) facilities. An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services.

MDHHS follows Medicare ASC coverage and reimbursement policy, but applies the current Outpatient Prospective Payment System (OPPS)/ASC reduction factor to arrive at the Medicaid ASC reimbursement rate. To facilitate coordination of benefits, ASC policy follows, as closely as possible and appropriate, Medicare's current ASC coverage policies, editing, and claim submission requirements.

1.1 MEDICARE CERTIFICATION

To be eligible for Michigan Medicaid enrollment and payment, ASCs must be certified as meeting the requirements for a Medicare ASC and must enter into an agreement with the Centers for Medicare & Medicaid Services (CMS).

SECTION 2 - COVERED SERVICES

MDHHS follows Medicare's ASC coverage policies, with Medicaid-specific exceptions outlined by code. MDHHS-specific exceptions are outlined as part of the MDHHS Ambulatory Surgical Centers (ASC) Wraparound Code List. Updates are published quarterly on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.1 ASC PAYMENT - STATUS INDICATORS

The Centers for Medicare & Medicaid Services (CMS) assigns a two-digit status indicator to each Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code identifying if a code will be paid and how it will be paid. MDHHS has adopted the CMS ASC status indicators.

For categories of codes that MDHHS covers differently than Medicare (wraparound codes), the following alpha/numeric status indicators are used:

Status Indicator	Description
AA1	MDHHS Covered /Medicare Non-Covered
AA2	MDHHS Covered
AA3	Vaccines for Children (VFC)
AA4	State Plan Reimbursement
RR1	MDHHS Non-Covered

SECTION 3 - ASC REIMBURSEMENT

The current OPPS/ASC reduction factor is applied to the current Medicare ASC reimbursement rate. The OPPS and ASC reduction rate is monitored and adjusted as necessary to assure payments do not exceed appropriated funding. Reimbursement for Ambulatory Surgical Center services will be monitored and adjustments will be made to the MDHHS reduction factor as necessary to ensure spending limits fall within the MDHHS appropriation. A wage index of 1.0 is applied for all Ambulatory Surgical Centers.

Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.1 PAYMENT CALCULATION

Payments for ASC facility services are calculated utilizing the following formula:

Medicare ASC rate	**X**	Current OPPS/ASC reduction factor	**=**	Medicaid ASC Rate

The MDHHS payment is the lesser of:

- the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or
- (for fee schedule items) the provider's charge, reduced by any contractual adjustments, and minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or
- the beneficiary's liability for coinsurance, copayments, and/or deductibles.

3.2 PACKAGED SERVICES

MDHHS follows Medicare guidelines for packaged/bundled service costs. ASC services having a status indicator of "N1" are considered a packaged service/item and do not receive separate payment.

3.3 MULTIPLE PROCEDURES

MDHHS follows Medicare payment rules for multiple procedures.

3.4 BILATERAL PROCEDURES

MDHHS follows Medicare payment rules for bilateral procedures. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting.

3.5 DISCOUNTED PROCEDURES

MDHHS follows Medicare payment rules for discounted procedures.

3.6 Application of Statewide Outpatient Cost-to-Charge Ratio

Services paid by Medicare at reasonable cost and contractor-priced items are paid by applying the Medicaid statewide outpatient hospital cost-to-charge ratio to the Medicare ASC rate. The OPPS/ASC reduction factor is not applied. Updates of hospital cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios.

3.7 Ambulatory Surgical Centers Wraparound Code List Fee Schedule

Services listed in the MDHHS Ambulatory Surgical Centers (ASC) Wraparound Code List are paid based on a MDHHS-specific fee schedule. CMS updates are published quarterly on the MDHHS website (revisions are made to align with Medicare). The OPPS/ASC reduction factor is not applied to MDHHS Ambulatory Surgical Centers Wraparound Code List services. (Refer to the Directory Appendix for website information.)

3.8 Injections/Intravenous Infusions

MDHHS covers intramuscular, subcutaneous or intravenous injections, and intravenous (IV) infusions when medically necessary. A list of outpatient physician-administered drugs and biological products carved out from the Michigan Medicaid Health Plans (MHPs) is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

Refer to the Injectable Drugs and Biological Products section of the Practitioner chapter of this manual for additional information regarding prior authorization (PA) requirements. Refer to the Drugs and Biological Products Not Covered by Medicaid Health Plans section of the Billing & Reimbursement for Institutional Providers chapter of this manual for additional information regarding billing instructions.

3.9 Anesthesia Services

The ASC facility payment does not include the anesthesia provider's professional services. Claims for the provider's professional services must be submitted on a separate and distinct claim from the ASC facility claim.

SECTION 4 - ASC BILLING

Medicaid-enrolled ASCs are required to bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on the CMS 1500 paper claim form. Providers are encouraged to bill electronically.

BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

This chapter is comprised of two parts:

The **BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES** portion of the chapter outlines the PIHP requirements and services for specialty behavioral health and intellectual and developmental disability supports and services.

The **NON-PHYSICIAN BEHAVIORAL HEALTH APPENDIX** portion of the chapter includes requirements for psychologists, social workers, professional counselors, and marriage and family therapists providing outpatient behavioral health services not included under the specialty services and supports benefit.

BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Mental Health providers. Information contained in this chapter is to be used in conjunction with other chapters of this manual including the Billing & Reimbursement Chapters and the Practitioner Chapter, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

1.1 MDHHS APPROVAL

Pursuant to Michigan's Medicaid State Plan and federally approved managed care waiver, community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by MDHHS in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. Service providers may contract with the PIHP or an affiliate of the PIHP. PIHPs must be enrolled with MDHHS as Medicaid providers. (Refer to the General Information for Providers Chapter of this manual for additional information.) The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual.

1.2 STANDARDS

The PIHP shall comply with the standards for organizational structure, fiscal management, administrative record keeping, and clinical record keeping specified in this section. In order for a state plan or HSW service to be reported as a Medicaid cost, it must meet the criteria in this chapter.

1.2.A. NETWORK ADEQUACY STANDARDS FOR THE SPECIALTY BEHAVIORAL HEALTH SYSTEM

The Code of Federal Regulations at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of Network Adequacy Standards, including behavioral health and substance use disorder services for both adults and children. As such, MDHHS developed Network Adequacy Standards for the Prepaid Inpatient Health Plan system of care, including an authorizing policy and a companion procedural document that will be updated as necessary. The policy and procedural document can be found on the MDHHS website. (Refer to the Directory Appendix; Mental Health/Substance Abuse Resources section, for website information.)

1.3 ADMINISTRATIVE ORGANIZATION

The administrative organization shall assure effective and efficient operation of the various programs and agencies in a manner consistent with all applicable federal and state laws, regulations, and policies. Effective and efficient operation includes value purchasing. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services. Quality is measured by meeting or exceeding the sets of outcome specifications in the beneficiary's individual plan of service, developed through the person-centered planning process or, for

substance abuse services, the individualized treatment plan. Efficient and economic is the lowest cost of the available alternatives that has documented capacity to meet or exceed the outcome quality specifications identified in the beneficiary's plan. There shall be clear policy guidelines for decision-making and program operations and provision for monitoring same. The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements, and assist the beneficiary to make use of other community resources for non-Medicaid services, or Medicaid services administered by other agencies. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

1.4 Provider Registry

The PIHPs must register with MDHHS any Medicaid specialty services and support they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDHHS /PIHP contract. The PIHPs should contact the Division of Contracts and Quality Management for more information about the provider registry and for MDHHS approval of special programs. (Refer to the Directory Appendix for contact information.) PIHPs must update the registry whenever changes (address, scope of program, additions, deletions) occur, according to the format and schedule specified by MDHHS.

1.5 Programs Requiring Special Approval

Certain programs and sites require the PIHP to request specific approval by MDHHS prior to service delivery. Programs must be approved and certified by MDHHS prior to service provision in order to be reported as a Medicaid cost. (Refer to the Directory Appendix for contact information.) Programs previously approved by MDHHS and delivered by CMHSPs that are now affiliates do not need to be approved again unless otherwise directed by MDHHS.

Programs requiring specific approval and certification are:

- Assertive Community Treatment Programs
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Drop-in Programs
- Home-Based Services
- Intensive Crisis Stabilization for Adults and Children
- Wraparound and Children's Therapeutic Foster Care

The PIHP shall notify MDHHS of changes in providers of these programs or sites, including change of address or discontinuation.

1.6 Beneficiary Eligibility [Changes Made 4/1/2025]

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports

when their needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual's clinical record.

NOTE: When the assessment is driven by medical need, the MHP is responsible for coverage. Refer to the Practitioner chapter for further information.

Psychological and neuropsychological evaluation provided by professionals in the MHP network for mild to moderate conditions (e.g., attention deficit hyperactivity disorder [ADHD], anxiety disorders, obsessive-compulsive disorder [OCD], tic disorders) are the responsibility of the MHP.

The PIHP is responsible for further evaluation when severe concerns are suspected (i.e., Autism Spectrum Disorder [ASD], Intellectual Disability and serious emotional disturbance [SED]) and treatment if the beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need. If results of the completed screening do not determine the need for specialty behavioral health services such as SED or Autism, the beneficiary should be referred back to the primary care provider (PCP) for treatment or subsequent referral to the appropriate practitioner in the MHP network.

Medicaid fee for service (FFS) is responsible for coverage of behavioral health screening including, but not limited to, psychological and neuropsychological screening for FFS beneficiaries when performed by the PCP or other qualified provider. Psychological and neuropsychological evaluation, assessment, and treatment not included under the PIHP benefit and/or provided by a non-PIHP enrolled provider is also covered for FFS beneficiaries. The PIHP is responsible for further evaluation and treatment if the FFS beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need. Refer to the Non-Physician Behavioral Health Appendix of this chapter and the Practitioner chapter for additional information regarding program coverage of behavioral health services provided by non-PIHP enrolled providers. **(text revised 4/1/2025)**

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary's psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	**In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:**
▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability.	▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills).

▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine medication management without further specialized services and supports.	▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.

The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDHHS/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

1.7 Definition of Terms

This list of terms is not exhaustive, but rather the most commonly used terms, listed alphabetically:

Amount	The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.
Child Mental Health Professional	▪ A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor, licensed or limited licensed marriage and family therapist or registered professional nurse; or ▪ A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; or ▪ A person with at least a master's degree in a mental health-related field from an accredited school who is trained, and has one year of experience in the examination, evaluation, and treatment of minors and their families.
Covered Services or Medicaid Covered Services	For the purposes of this manual, Medicaid State Plan Services and specialty services and supports.
Duration	The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
Electronic Signature	An electronic method to obtain the signature of a Medicaid beneficiary and/or that of their legal representative/guardian to sign required documents, i.e., the plan of service or consents is acceptable. Using this method does not change the requirements for when a signature is mandated; therefore, a new electronic signature is obtained from the Medicaid beneficiary/legal representative/guardian. Electronic signatures must not be stored or saved to be re-used at will or for convenience.
Health Care Professional	A physician, registered nurse, physician assistant, nurse practitioner, clinical nurse specialist, or dietitian. Services provided must be relevant to the health care professional's scope of practice. Refer to the Staff Provider Qualifications in the Program Requirements Section of this chapter.
Individual Plan of Services (also referred to as the "plan" or "plan of services and supports" or "treatment plan" for beneficiaries receiving substance abuse treatment)	The document that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving mental health or developmental disabilities services, the individual plan of services must be developed through a person-centered planning process. In the case of minors with developmental disabilities, serious emotional disturbance or mental illness, the child and their family are the focus of service planning, and family members are an integral part of the planning process.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.

Mental Health Professional	A physician, psychologist, licensed master's social worker, licensed professional counselor, licensed marriage and family therapist, or registered nurse. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter.)
Prescription	A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of their practice under Michigan law that contains all of the following: ▪ Beneficiary's name; ▪ Prescribing practitioner's name, address and telephone number; ▪ Prescribing practitioner's signature (a stamped signature is not acceptable); ▪ The date the prescription was written; ▪ The specific service or item being prescribed; ▪ The expected start date of the order (if different from the prescription date); and ▪ The amount and length of time that the service or item is needed. A verbal order from a physician or other licensed practitioner of the healing arts within their scope of practice may be used to initiate occupational therapy (OT), physical therapy (PT), or Speech, Hearing and Language services or to dispense medically necessary equipment or supplies when a delay would be medically contraindicated. The written prescription must be obtained within 14 days of the verbal order. The qualified therapist (OT, PT or Speech) responsible for furnishing or supervising the ordered service, supports coordinator or case manager must receive and document the date of the verbal order in the individual plan of service. Upon receipt of the signed prescription, it shall be verified with the verbal order and entered into the individual plan of service.
Qualified Mental Health Professional (QMHP)	An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMHP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.) NOTE: If an individual was hired and performed the role of a QMHP prior to January 1, 2008 and later transfers to a new agency, their QMHP status will be grandfathered into the new agency.
Qualified Intellectual Disability Professional (QIDP)	An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has an intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.) NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, their QIDP status will be grandfathered into the new agency.

Scope of Service	The parameters within which the service will be provided, including: ▪ Who (e.g., professional, paraprofessional, aide supervised by a professional); ▪ How (e.g., face-to-face, telephone, taxi or bus, group or individual); and ▪ Where (e.g., community setting, office, beneficiary's home); and ▪ Frequency of Service(s) (e.g., daily, weekly, monthly, quarterly). The state is responsible to review the adequacy of service plans for Medicaid beneficiaries. This includes reviewing to ensure that services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. The requirements for the service plan are listed in 42 CFR 441.725, Michigan Mental Health Code (MMHC) 330.1700-1712 and Michigan Administrative Code R330.7199.
Substance Abuse Treatment Specialist	▪ An individual who has licensure in one of the following areas, and is working within their scope of practice: ➢ Clinical Nurse Specialist (CNS) ➢ Licensed Bachelor's Social Worker (LBSW) ➢ Licensed Marriage and Family Therapist ➢ Licensed Master's Social Worker (LMSW) ➢ Licensed Practical Nurse (LPN) ➢ Licensed Professional Counselor (LPC) ➢ Licensed Psychologist (LP) ➢ Limited Licensed Bachelor's Social Worker (LLBSW) ➢ Limited Licensed Marriage and Family Therapist ➢ Limited Licensed Master's Social Worker (LLMSW) ➢ Limited Licensed Professional Counselor (LLPC) ➢ Limited Licensed Psychologist (LLP) ➢ Nurse Practitioner (NP) ➢ Physician (MD, DO) ➢ Physician Assistant (PA) ➢ Registered Nurse (RN) ➢ Temporary Limited Licensed Psychologist (TLLP) and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the regional PIHP; or • An individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC & RC) credentials: ➢ Certified Advanced Alcohol and Drug Counselor – IC & RC (CAADC) ➢ Certified Alcohol and Drug Counselor – IC & RC (CADC)

	➢ Certified Alcohol and Drug Counselor – Michigan (CADC-M) ➢ Certified Co-Occurring Disorders Professional – IC & RC (CCDP) ➢ Certified Co-Occurring Disorders Professional Diplomat – IC & RC (CCDP-D) ➢ Certified Criminal Justice Professional – IC & RC - Reciprocal (CCJP-R) or; ▪ An individual who has one of the following approved alternative certifications: ➢ for medical doctors: American Society of Addiction Medicine (ASAM) ➢ for psychologists: American Psychological Association (APA) specialty in addiction ➢ for counselors/therapists: Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD) ➢ for Licensed Professional Counselors: National Certified Counselor (NCC) with concurrent Master Addictions Counselor (MAC) certification A physician (MD, DO), physician assistant, nurse practitioner, registered nurse, clinical nurse specialist, or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the appropriate MCBAP/IC & RC credential applies.
Substance Abuse Treatment Practitioner	An individual who has a registered MCBAP certification development plan (Development Plan – Counselor (DP-C) – approved development plan in place), is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC (CCS); or who has a registered development plan to obtain the supervisory credential (Development Plan – Supervisor (DP-S) – approved development plan in place) while completing the requirements of the plan (6000 hours).

1.8 CONFIDENTIALITY

MDHHS complies with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary, and protects this relationship using the minimum amount of information necessary for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or their representative, unless the provider has a signed release from the beneficiary/parent/guardian/legal representative or the disclosure is for a permitted purpose under all applicable confidentiality laws.

If the provider questions the appropriateness of releasing beneficiary records, the provider is encouraged to seek legal counsel before doing so.

1.8.A. STANDARD CONSENT FORM

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The

consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

1.9 Electronic Signature

An electronic method to obtain the signature of a Medicaid beneficiary and/or that of their legal representative/guardian to sign required documents, i.e., the plan of service or consents is acceptable. Using this method does not change the requirements for when a signature is mandated; therefore, a new electronic signature is obtained from the Medicaid beneficiary/legal representative/guardian. Electronic signatures must not be stored or saved to be re-used at will or for convenience.

SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/1915(i) SPA) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which they are entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of their plan of services within 15 business days of completion of the plan.
- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or their guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and their guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.
- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.

2.2 SUBSTANCE ABUSE SERVICES

Substance abuse services must be furnished by service providers licensed by the State of Michigan to provide each type of substance abuse services for which they contract. Substance abuse service providers also must be accredited as an alcohol and/or drug abuse program by one of the following national accreditation bodies:

- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities (CARF);

- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA);
- National Committee on Quality Assurance (NCQA); or
- Accreditation Association for Ambulatory Health Care (AAAHC).

Substance abuse services must be coordinated with other community services as appropriate to an individual's needs and circumstances. Services must also be provided according to an individualized treatment plan. All standard requirements of the Michigan Public Health Code, Article 6 - Substance Abuse apply.

2.3 Location of Service [Changes Made 4/1/2025]

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

For beneficiaries residing in nursing facilities, only the following clinic services may be provided:

- Nursing facility mental health monitoring;
- Psychiatric evaluation;
- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered to beneficiaries with a Serious Mental Illness (SMI) in Institutions for Mental Diseases (IMD) for individuals between ages 21 and 64, as specified in §1905(a)(B) of the Social Security Act when the length of stay in the IMD is more than 15 days during the month. However, per Michigan's 1115 Behavioral Health Demonstration, Medicaid does cover services delivered to beneficiaries with a Substance Use Disorder (SUD) in IMDs for individuals between ages 21 and 64 when the stay in the IMD is more than 15 days during the month. Medicaid does not

cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of a State Hospital. For both the CCI and State Hospital, the following mental health services initiated by the PIHP (the child needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes:

- The assessment of a child's eligibility and needs for the purpose of determining the community based services necessary to transition the child out of a CCI or State Hospital. This should occur up to 180 days prior to the anticipated discharge from a CCI or State Hospital.
- Intensive Care Coordination with Wraparound (ICCW) planning, case management or supports coordination. This should occur up to 180 days prior to discharge from a CCI or State Hospital. **(revised 4/1/2025)**

Medicaid-funded behavioral health services may be provided to support children with intellectual and developmental disabilities (I/DD) in a CCI that exclusively serves children with I/DD when authorized by the respective PIHP/CMHSP. Authorization by the PIHP/CMHSP includes special considerations, services and/or funding arrangements. Enrollment of the CCI provider is the responsibility of the PIHP/CMHSP to ensure providers rendering services adhere to all state and federal regulations on the use of seclusion and restraint and are appropriately credentialed to perform I/DD services.

Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

Refer to the Amount and Scope of Service subsection for additional information regarding Wraparound program expectations.

2.4 Staff Provider Qualifications

Providers of specialty services and supports (including state plan, HSW, and additional/1915(i) SPA) are chosen by the beneficiary and others assisting them during the person-centered planning process, and must meet the staffing qualifications contained in program sections in this chapter. In addition, qualifications are noted below for provider staff mentioned throughout this chapter, including the Children's Waiver. The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Credentialing and re-credentialing standards located in the Quality Assessment and Performance Improvement Program in the MDHHS/PIHP contract must be followed. Michigan laws regarding licensing and registration of professionals are found in the Public Health Code, the Mental Health Code and the Michigan Administrative Rules. These regulations define the scope of practice for each professional as well as requirements for supervision.

All providers must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.

- In good standing with the law according to the MDHHS/PIHP contract.

Aides	Must be able to perform basic first aid procedures. Waiver aides must also successfully complete training in recipient rights and implementation of the individual plan of services. For the full list of aide qualifications, refer to the Habilitation Supports Waiver for Persons with Developmental Disabilities section, Aide Qualifications subsection.
Audiologist	A licensed individual; has the equivalent educational requirements and work experience necessary for the license; or has completed the academic program and is acquiring supervised work experience to qualify for the license.
Clinical Nurse Specialist	An individual licensed as a registered professional nurse who has been granted a specialty certification as a clinical nurse specialist by the Michigan Board of Nursing under section 17210.
Dietitian	An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the Academy of Nutrition and Dietetics.
Licensed Practical Nurse (LPN)	An individual who is licensed by the State of Michigan to practice as a licensed practical nurse under the supervision of a registered nurse, physician, or dentist. LPNs include licensed psychiatric attendant nurses per MCL§ 333.17209.
Nurse Practitioner (NP)	An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.
Occupational Therapist (OT)	An individual who is licensed by the State of Michigan to practice as an occupational therapist.
Occupational Therapy Assistant (OTA)	An individual who is licensed by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.
Physical Therapist (PT)	An individual licensed by the State of Michigan as a physical therapist.
Physical Therapy Assistant	An individual who is a graduate of a physical therapy assistant associate degree program accredited by an agency recognized by the Commission on the Accreditation in Physical Therapy Education (CAPTE), and who is supervised by the physical therapist licensed by the State of Michigan. The individual must be supervised by the physical therapist licensed by the State of Michigan.
Physician (MD or DO)	An individual who possesses a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Administration (DEA) registration.
Physician Assistant	An individual licensed by the State of Michigan as a physician assistant. Practice as a physician assistant means the practice of medicine with a participating physician under a practice agreement.
Professional Counselor	An individual who is fully licensed or limited-licensed by the State of Michigan to practice professional counseling. This includes Rehabilitation Counselors.
Psychologist	An individual who possesses a full license by the State of Michigan to independently practice psychology; or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a limited-licensed psychologist (LLP); or a master's degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a temporary-limited-licensed psychologist.

Registered Nurse (RN)	An individual licensed by the State of Michigan to practice nursing (MCL 333.17201).
Social Worker	An individual who possesses Michigan licensure as a master's social worker, or Michigan licensure as a bachelor's social worker, or has a limited license as a bachelor's social worker or master's social worker. Limited licensed social workers must be supervised by a licensed MSW (MCL 333.18501 - 507).
Speech Pathologist (SLP)	An individual engaged in the practice of Speech-Language Pathology and is licensed by the State of Michigan to provide such services.

Refer to the Behavioral Health Code Charts and Provider Qualifications document on the MDHHS website for specific provider qualifications for each covered service. (Refer to the Directory Appendix for website information.)

2.5 Medical Necessity Criteria

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. Medical Necessity Criteria

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve their goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. Determination Criteria

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. Supports, Services and Treatment Authorized by the PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP Decisions

Using criteria for medical necessity, a PIHP may:

- Deny services:
  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
  - that are experimental or investigational in nature; or
  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

SECTION 3 – COVERED SERVICES

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/1915(i) SPA services described in the Behavioral Health §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment section of this chapter. The PIHP is not responsible for providing state plan covered services that MDHHS has designated another agency to provide (refer to other chapters in this manual for additional information, including the chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance). However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended. NOTE: Certain services are State Plan EPSDT services when delivered to children birth-21 years. Each affected service is appropriately identified within the subsections.

3.1 BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

Refer to the Behavioral Health Treatment Services/Applied Behavior Analysis Section of this chapter for specific program requirements.

3.2 ASSERTIVE COMMUNITY TREATMENT

Refer to the Assertive Community Treatment Program (ACT) Section of this chapter for specific program requirements.

3.3 ASSESSMENTS

Health Assessment	Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, clinical nurse specialist, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietician.
Psychiatric Evaluation	A comprehensive evaluation performed face-to-face by a psychiatrist, physician, psychologist, master's social worker, licensed professional counselor, marriage and family therapist, nurse practitioner, clinical nurse specialist or licensed physician's assistant who investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary based on a recovery model of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.

Psychological Testing	Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists. The beneficiary's clinical record must indicate the name of the person who administered the tests, the results of the tests, the actual tests administered, and any recommendations. The protocols for testing must be available for review.
All Other Assessments and Testing	Generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional within their scope of practice for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. For children/youth who have experienced trauma or have an elevated score on a trauma screener, a standardized, validated trauma assessment tool, appropriate for the age of the child, is utilized to inform the treatment needs of the beneficiary. The MichiCANS Screener is the tool required at the point of access for infants, toddlers, children, youth and young adults ages birth through 20 years of age (day prior to 21). Depending on the results of the MichiCANS Screener, the MichiCANS Comprehensive will be used at initial intake, annually thereafter, and at time of exit for infants, toddlers, young children, youth, and young adults ages birth through 20 to guide treatment service planning. The MichiCANS must be administered by staff who have been trained and certified in the use of the MichiCANS. The Devereux Early Childhood Assessment (DECA) must be used at intake and during treatment planning, based on the results of the MichiCANS Screener for infants, toddlers, and children ages one month and through age 5 (day prior to 6) who have a Serious Emotional Disturbance (SED) or have SED and Intellectual/Developmental Disabilities (IDD). The assessment must be performed by staff who have been trained in the implementation of the DECA. Refer to the MichiCANS section of this chapter for additional information.

3.4 Behavior Treatment Review

The federal Balanced Budget Act of 1997 requires states to ensure that enrollees in their PIHPs will "be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints or seclusion" [42 CFR 438.100 (b)(2)(v)].

A behavior treatment plan (BTP), where needed, is developed through the person-centered planning process that involves the beneficiary. To determine the need for a BTP, a comprehensive assessment must be completed in order to rule out any physical or environmental cause for the behavior. Any BTP that includes limitations of the beneficiary's rights, any intrusive behavior treatment techniques, or any use of psychoactive drugs for behavior control purposes, must be reviewed and approved by a Behavior Treatment Plan Review Committee (BTPRC) comprised of at least three individuals, one of whom shall be a board-certified behavioral analyst or licensed behavior analyst and/or fully- or limited-licensed psychologist with the specified training, and one of whom shall be a licensed physician/ psychiatrist. A representative of the Office of Recipient Rights (ORR) shall participate on the BTPRC as ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the BTPRC's discretion and with the consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

Exception: Limitations of the beneficiary's rights, any intrusive treatment techniques, or any use of psychoactive drugs where the beneficiary's challenging behavior is due to the active symptoms of a serious mental illness and serious emotional disturbance (as defined in Chapter 1 of the Mental Health

Code [MHC]). Any limitation shall be justified, time-limited, and clearly documented in the individual plan of service (IPOS). Documentation shall be included that describes attempts that have been made to avoid limitations, as well as what actions will be taken as part of the IPOS to ameliorate or eliminate the need for the limitations in the future.

The required BTPRC members must be present during the review and approval process. A BTPRC member who has prepared a BTP for a specific beneficiary must recuse themselves from the final decision-making of that individual. Any BTP submitted for review and approval (or disapproval) must be done in light of current research and prevailing standards of practice as found in current peer-reviewed psychological/psychiatric literature. Any intrusive or restrictive technique not supported in current peer-reviewed psychological/psychiatric literature must be reviewed and approved by MDHHS prior to implementing. BTPs that propose the use of physical management and/or involvement of law enforcement in a non-emergent situation, aversive techniques, or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the BTPRC. Acceptable BTPs are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal and social relationships. Such reviews shall be completed prior to the beneficiary's signing and implementation of the BTP and as expeditiously as possible. Staff implementing the beneficiary's BTP must be trained in how to implement the BTP. This coverage includes the monitoring of the BTP by the BTPRC or a designee of the committee which shall occur as indicated in the BTP.

3.5 Child Therapy

Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis with a family-driven, youth-guided approach.

Telemedicine is approved for Individual Therapy or Family Therapy using approved children's evidence-based practices (i.e., Trauma Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon, Parenting Through Change) and utilizes the GT modifier when reporting the service. Qualified providers of children's evidence-based practices have completed their training in the model, its implementation via telehealth, and are able to provide the practice with fidelity.

Telemedicine is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed therapy services may be prohibitive). Telemedicine must be obtained through real-time interaction between the child's/family's physical location and the provider's physical location. Telemedicine services are provided to patients through hardwire or internet connection. It is the expectation that providers involved in telemedicine are trained in the use of equipment and software prior to servicing children/families.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. Refer to the Telemedicine Chapter for additional information.

3.6 Clubhouse Psychosocial Rehabilitation Programs

Refer to the Clubhouse Psychosocial Rehabilitation Programs Section of this chapter for specific program requirements.

3.7 Crisis Interventions

Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.

The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure themself, or another individual, either intentionally or unintentionally.
- The individual is unable to provide themself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the mental health professional, their continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

3.8 Crisis Residential Services

Refer to the Crisis Residential Services Section of this chapter for specific program requirements.

3.9 Family Therapy

Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. For children and youth, a family-driven, youth-guided planning process should be utilized. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker. When providing trauma specific intervention for infants, toddlers (birth through 47 months) and their family member(s) or other person(s) significant to the beneficiary (i.e., Child Parent Psychotherapy), the mental health professional, or limited licensed master's social worker supervised by a fully licensed master's social worker, must minimally have endorsement as an Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred.

3.10 Health Services

Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under the Assessments subsection above. A registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

3.11 Home-Based Services

Refer to the Home-Based Services Section of this chapter for specific program requirements.

3.12 Individual/Group Therapy

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.

3.13 Inpatient Psychiatric Hospital Admissions

Refer to the Inpatient Psychiatric Hospital Admissions Section of this chapter for specific program requirements.

3.14 Intensive Crisis Stabilization Services

Refer to the Intensive Crisis Stabilization Services Section of this chapter for specific program requirements.

3.15 Intermediate Care Facility for Individuals With Intellectual Disabilities (ICF/IID) Services

Health and rehabilitative services provided in a state-licensed facility of 16 beds or less that is certified to meet ICF/IID standards that are specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified intellectual disability professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications.

3.16 Medication Administration

Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, physician assistant, nurse practitioner, clinical nurse specialist, or registered nurse may perform medication administration under the direction of the physician. A licensed practical nurse or certified medical assistant who is assisting a physician may perform medication administration as long as the physician is on-site.

For injections administered through the CMHSP clinic, refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual.

3.17 Medication Review

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

3.18 Nursing Facility Mental Health Monitoring

This service is the review of the beneficiary's response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or needs of a nursing facility resident. It is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary. Nursing facility mental health monitoring can be provided by a physician, physician assistant, clinical nurse specialist, or nurse practitioner. If nursing facility mental health monitoring is provided by a limited licensed master's social worker or limited licensed bachelor's social worker, they must be supervised by a licensed master's social worker. If monitoring is provided by a licensed bachelor's social worker or a registered nurse, they need to be supervised by a professional. A "professional" is a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed master's social worker, professional counselor, QIDP or QMHP.

3.19 Occupational Therapy

Evaluation	Therapy
Physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable).

Evaluation	Therapy
	Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.
	Services must be prescribed by a physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.

3.20 Outpatient Partial Hospitalization Services

Refer to the Outpatient Partial Hospitalization Services Section of this chapter for specific program requirements.

3.21 Peer-Delivered or -Operated Support Services

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Peer-delivered or peer-operated support services are programs and services that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

3.21.A. Drop-In Centers

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active

assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

PIHPs must seek approval from MDHHS prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:

- Staff and board of directors of the center are 100% primary consumers;
- PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program;
- PIHP facilitates consumers' ability to handle the finances of the program;
- The drop-in center is at a non-CMH site;
- The drop-in center has applied for 501(c)(3) non-profit status;
- There is a contract between the drop-in center and the PIHP, or its subcontractor, identifying the roles and responsibilities of each party; and
- There is a liaison appointed by the PIHP to work with the program.

Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in specified in their IPOS, it must be documented to be medically necessary and identify:

- Goals and how the program supports those goals; and
- The amount, scope and duration of the services to be delivered.

The individual clinical record provides evidence that the services were delivered consistent with the plan.

3.21.B. Peer Specialist Services [Changes Made 4/1/2025]

Peer support specialists are individuals with a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption. A substantial life disruption is defined as experiencing some or all of the following: homelessness, mental health crises, trauma, lack of employment, criminal justice involvement, discrimination, stigma/prejudice intensified by mental health challenges, receiving public benefits due to poverty.

Beneficiaries share mutual experiences in their journey of recovery with the peer support specialist. This mutuality is the foundation of what is referred to as "peerness" between a peer support specialist and a beneficiary seeking recovery, promoting connection, and offering hope. As a state and national expectation, peer support specialists are trained and skillful in sharing their recovery story as a method of engaging beneficiaries.

Peer support specialists inspire hope and support others experiencing similar situations. Through shared understanding and respect, they support people to become and stay engaged in the recovery process. Serving in a role as a community health worker, they

support the beneficiary with their personal wellness and recovery. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process. Peer support specialists assist people in recovery to connect with their own inner strength, motivation, and desire to move forward in life, even when experiencing challenges.

Peer support specialists provide services and supports based on medical necessity criteria that is designed to assist the beneficiary to achieve their goals of community inclusion and participation, independence, recovery, resiliency and/or productivity. This medical necessity criteria is included in the person-centered planning process; listed in amount, scope and duration, and documented in the individual plan of service.

Depending on their position description that is developed specifically by each individual agency, services that peer support specialists provide may include:

- Sharing their story through their lived experience of moving from hopelessness to hope;
- Co-facilitation with the beneficiary in development and implementation of recovery goals in the individual plan of service completed through a person-centered planning process;
- Integration of physical and mental health care, including the development of wellness plans;
- Developing, implementing and providing health and wellness supports to address preventable risk factors for chronic conditions;
- Advocate and assist with opportunities to engage in self-directed care;
- Developing, implementing and facilitating support groups;
- Providing supportive services during and after crises;
- Supporting beneficiaries in completing psychiatric advance directives;
- Accessing benefits and utilizing public assistance;
- Navigating challenging and complex systems of care;
- Linking and engaging the beneficiary to community resources and formal/informal supports;
- Vocational assistance and support;
- Promoting, improving and educating whole health and self-management of chronic conditions;
- Housing assistance and support;
- Active engagement with individuals who have criminal justice involvement;
- Applies and models the five stages of recovery to assist beneficiaries in achieving their personal recovery goals.

As an evidence-based practice, peer support is valuable not only for the person receiving services but also for behavioral health and integrated care professionals, including the systems in which they work. Peer support specialists educate their colleagues and advocate for and advance the field by sharing their perspectives, recovery stories, and

experience in order to increase understanding of how recovery practices and policies may be improved to promote health and wellness. Research and experience show that peer support specialists have a transformative effect on both individuals and systems. Peer support has been shown to improve quality of life, improve engagement and satisfaction with services and supports, improve whole health -- including chronic conditions, decrease hospitalizations and inpatient days, and reduce the overall cost of services.

Supervision Requirements	Peer supervisors may include MDHHS certified peers who have over two continuous years in recovery and over two years in the direct provision of services. Other peer supervisors must be credentialed, certified, licensed or degreed in the field within which the peer is working. **(text revised 4/1/2025)**
Certification Requirements	Individuals who are working as peer support specialists in a Medicaid service delivery system serving beneficiaries with mental health conditions must: ▪ Be at least 18 years of age; ▪ Have a high school diploma, General Education Diploma (GED), or provide college transcripts in lieu of a high school diploma or GED; ▪ Have a primary diagnosis of a mental health condition; ▪ Have a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption; ▪ Have been a recipient of mental health treatment and/or services for at least one year, with a substantial life disruption due to their mental health condition; ▪ Have personal experience in navigating complex mental health treatment services; ▪ Self-identify as having a mental health condition with a substantial life disruption and share their recovery story in supporting others; ▪ Be employed by a CMHSP or contract provider at the beginning of training; ▪ Meet the MDHHS application approval process for specialized training and certification: ➢ Completed peer support specialist application ➢ Supervisor signature and acknowledgment form ➢ Two written letters of reference ➢ Current job description ➢ Read, understand, and agree to peer code of ethics ➢ Acknowledgement of truthfulness and accuracy of application ➢ Peer-to-peer interview ➢ Training fee paid by the agency that employs the peer support specialist; ▪ Attend professional advancement opportunities to maintain skills; ▪ Be freely chosen by beneficiaries utilizing peer support services; and

	▪ Adhere to the MDHHS Peer Support Specialist Code of Ethics.
Continuing Education Requirements	▪ Must complete the 32 hours of approved continuing education bi-annually as determined by MDHHS. **(text added 4/1/2025)**

3.21.C. PEER RECOVERY COACH SERVICES [CHANGES MADE 4/1/2025]

Peer Recovery Coach Services	Peer Recovery Coach services are provided by a person in a journey of recovery from substance use, co-occurring disorders, and/or non-substance addictive disorders, and who identifies with a beneficiary based on a shared background and lived experience. The Peer Recovery Coach serving in a role as a community health worker (CHW) operates as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as each individual determines their own way. The Peer Recovery Coach helps to remove barriers and obstacles, assists with practices of harm reduction, and links the beneficiary to resources in the recovery community. Services provided by peer recovery coaches support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery. Peer Recovery Coaches embody a powerful message of hope, assisting beneficiaries to achieve goals of community inclusion and participation, independence, recovery, resiliency and/or productivity. This medical necessity criteria assists the peer recovery coach with setting recovery goals, developing recovery action plans, and supporting beneficiaries to live a full and meaningful life in the community through the individualized treatment planning process. The peer recovery coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery. Utilizing a strength-based perspective and emphasizing assessment of recovery capital (utilizing the total resources a beneficiary has to find and sustain recovery), services are designed to include prevention strategies and the integration and coordination of physical and behavioral health services to help attain and maintain recovery and prevent relapse. Building upon the strong foundation of a recovery-oriented philosophy and evidence-based practices (EBPs), peer recovery coaches may offer Screening, Brief Intervention, & Referral to Treatment (SBIRT) to a full continuum of SUD treatment and recovery supports. Peer recovery coaches work in a variety of settings providing successful engagement in treatment and transitions across all levels of care for beneficiaries with high-risk and complex care needs. Some of the settings where peer recovery coaches may provide services include residential treatment facilities, Medication Assisted Treatment (MAT) programs, Recovery Community Organizations (RCO), hospital emergency rooms, Substance Use Disorder Health Homes (SUDHH), housing programs, outpatient treatment and prevention, drug courts and other justice involved settings. Individuals who have been certified by Connecticut Community for Addiction Recovery (CCAR), Michigan Certification Board for Addiction Professionals (MCBAP), or Genesee Health System approved curriculum prior to January 1, 2018, may request a previous standards application.
Supervision Requirements	Peer supervisors may include MDHHS certified peers who have over two continuous years in recovery and over two years in the direct provision of peer services. Other

	peer supervisors must be credentialed, certified, licensed or degreed in the field within which the peer is working. **(text revised 4/1/2025)**
Requirements	Individuals who work as a Peer Recovery Coach serving beneficiaries with substance use or co-occurring disorders must: ▪ Be at least 18 years of age; ▪ Have a high school diploma, General Education Diploma (GED), or provide college transcripts in lieu of a high school diploma or GED; ▪ Have a SUD, co-occurring disorder(s), and/or non-substance addictive disorder(s) and have received treatment from a public or private provider; ▪ Have two continuous years in recovery at some point in time after the age of 18; ▪ Share their recovery story as a tool in helping others; ▪ Have personal experience in navigating complex SUD, co-occurring disorder(s), and/or non-substance addictive disorder(s) treatment services (self-help groups are not included); ▪ Self-identifies as having a substance use disorder, co-occurring disorder(s), and/or non-substance addictive disorder(s) with a substantial life disruption and shares their recovery story in supporting others; ▪ Be employed by a CMHSP or contract provider at the beginning of training; ▪ Meet the MDHHS application approval process for specialized training and certification. The process includes: ➢ Completed peer recovery coach application ➢ Supervisor signature and acknowledgment form ➢ Two written letters of reference ➢ Current job description ➢ Read, understand, and agree to the MDHHS Peer Recovery Coach Code of Ethics ➢ Acknowledgement of truthfulness and accuracy of application ➢ Peer-to-peer interview ➢ Training fee paid by the agency that employs the peer recovery coach ➢ Be freely chosen by beneficiaries utilizing peer recovery coach services ➢ Adhere to the MDHHS Peer Recovery Coach Code of Ethics.
Continuing Education Requirements	▪ Must complete the 32 hours of approved continuing education bi-annually as determined by MDHHS. **(text added 4/1/2025)**

3.21.D. Youth Peer Support Services

Youth Peer Support is a peer-delivered service for youth and young adults. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of non-judgmental support, connection through lived experience and supporting self-advocacy.

This service supports youth and young adult voice as part of the Family-Driven, Youth-Guided/Person-Centered approach to treatment and occurs as part of the treatment process. The goals of Youth Peer Support include supporting youth and young adults in their mental health journey by building a strong relationship based on mutual respect and strategic self-disclosure to increase hope, confidence, self-advocacy skills, and decision-making abilities.

Youth Peer Support is a relationship-based service that focuses on supporting youth and young adult empowerment by connecting to the emotions related to living with mental health challenges as a youth or young adult. It is not intended to substitute for other services such as respite, community living support services, or transition-specific support services.

Youth Peer Support Specialists must have direct lived experience with mental health challenges as a youth. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals, to support the youth or young adult's mental health, will be mutually identified in active collaboration with the youth or young adult receiving services and must be delivered by a Youth Peer Support Specialist with lived experience.

Youth Peer Support is intended to be provided to children, youth, and young adults who are middle school to 26 years of age. It is not intended to substitute for other services such as respite or community living support services. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team.

Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must actively participate in and complete the approved MDHHS curriculum, ongoing certification, and recertification requirements. Qualifications for the Youth Peer Support Specialist include:

- Young adult, ages 18 through 28, with lived experience with mental health challenges as a youth and who received mental health support as a youth or young adult.
- Willing and able to self-identify as a person who has received or is receiving behavioral health services and is prepared to use that experience in helping others.
- Experience receiving services in a variety of systems (such as child welfare, education, the justice system, vocation, housing, etc.) as a youth or young adult is preferred.
- Employed by PIHP/CMHSP or its contract providers.
- Trained in the MDHHS approved curriculum and ongoing certification and recertification model.

3.21.E. Peer Mentoring Services

Peer Mentoring services provide adults with intellectual and developmental disabilities with opportunities to support, mentor and assist beneficiaries to achieve community

inclusion and participation, independence, and productivity. Peer Mentors are individuals with intellectual and developmental disabilities who have a unique skill level from their experience in utilizing services and supports to achieve their goals. Peer Mentors offer the benefit of their personal experiences, passing along encouragement and support to help others construct their own advocacy. Beneficiaries utilizing Peer Mentoring services must freely choose the individual who is providing Peer Mentoring services from available trained Peer Mentors.

Activities provided by Peer Mentors are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, and productivity by:

- sharing personal stories of advocacy for the purpose of supporting self-advocacy and independence, person-centered planning goals, and arrangements that support self-direction;
- navigating transportation systems;
- building bridges to people and resources within the community;
- identifying recreation opportunities;
- providing information on entitlements;
- assisting beneficiaries to move towards independence;
- providing housing information by helping to identify affordable and accessible housing for achieving independent living; finding and choosing roommates; making applications for Section 8 Housing vouchers; managing budgets;
- providing vocational information to beneficiaries who are seeking post-secondary education and/or training opportunities, finding a job, and achieving successful employment.

Requirements

Individuals who are functioning as Peer Mentors serving beneficiaries with intellectual and developmental disabilities must:

- be 18 years of age.
- have an intellectual/developmental disability.
- attend the Michigan Developmental Disabilities Council's Peer Mentor 101 training by referral from their local CMHSP.
- complete a supervised 90-120 hour internship at their local CMHSP. (The CMHSP is expected to hire the individual after certification.)
- share their personal experiences to guide and support beneficiaries.
- participate in annual continuing education trainings to maintain skills and expand knowledge base.

The use of the Peer Mentor code for billing purposes is permissible only after the individual is certified by the Michigan Developmental Disabilities Council.

3.22 Personal Care in Licensed Specialized Residential Settings

Refer to the Personal Care in Licensed Specialized Residential Settings Section for specific program requirements.

3.23 Physical Therapy

Evaluation	Therapy
Physician/licensed physician's assistant-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.	It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered. Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage. Services must be prescribed by a physician/licensed physician's assistant and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.

3.24 Prevention-Direct Service Models [Changes Made 4/1/2025]

Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, social, emotional or cognitive dysfunction and increase the beneficiary's behavioral functionality, resilience and optimal mental health, thus reducing the need for individuals to seek treatment through the public mental health system. Prevention-direct service models are:

- Infant and Early Childhood Mental Health Consultation (IECMHC) **(revised 4/1/2025)**

- School Success Programs
- Children of Adults with Mental Illness/Integrated Services (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)
- Infant Mental Health when not enrolled as a Home-Based program
- Parent Education (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)

Coverage includes:

Infant and Early Childhood Mental Health Consultation (IECMHC) (revised 4/1/2025)	Infant and Early Childhood Mental Health Consultation (IECMHC) **(revised 4/1/2025)** provides consultation to child care providers and parents/caregivers who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings (non K-12 settings). Sometimes these challenges may put children at risk of suspension and/or expulsion from the childcare setting. IECMHC aims to reduce expulsion and increase the number of parents/caregivers and child care providers who successfully nurture the social and emotional development of children 0-5 in child care settings. IECMHC programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes: ▪ Observation and identification of provider capacity to meet the social and emotional needs of the infant, toddler or young child within their care. ▪ Strategies are identified for implementation by the IECMH Consultant in partnership with the childcare providers and Great Start Readiness Program provider and caregivers. **(text revised 4/1/2025)** ▪ Intervention (e.g., coaching, training and support for parents/caregivers and providers to build their reflective capacity, learn new ways to interact with the child to build their social-emotional skills and resilience, by providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis, and referral for ongoing mental health services, if needed). Provider qualifications: ▪ Master's prepared early childhood mental health professional plus specific training in the evaluated model as approved by MDHHS. Training requirement must, at a minimum, include Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred.
School Success Program	Works with parents of children, 6 years and above, so that they can be more involved in their child's life, monitor and supervise their child's behaviors; works with youth to develop pro-social behaviors, coping mechanisms, and problem solving skills; and consults with K-12 teachers, administrators and support staff in order to assist them in developing relationships with these students. Mental Health staff also act as a liaison between home and school. Provider qualifications: ▪ Child Mental Health Professional

Children of Adults with Mental Illness/Integrated Services	Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the public mental health system and to improve outcomes for adult beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the adult beneficiaries related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the service plan through a person-centered planning process for the adult beneficiary who is a parent. Linking the adult beneficiary and child to available community services, respite care and providing for crisis planning are essential components. Provider qualifications: ▪ Mental Health Professional
Infant Mental Health	Provides home-based parent-infant support and therapeutic intervention services, using the evaluated Infant Mental Health Home Visiting model (perinatal people, birth to 36 months), to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder and promote healthy attachment, resilience and optimal mental health for both the infant and parent/primary caregiver. PIHPs or their provider networks may provide infant mental health services, in the home or community based setting, as a specific service when it is not part of a MDHHS-certified home-based program. **(text revised 4/1/2025)** Provider qualifications: ▪ Masters-prepared early childhood mental health professional plus specific training. Training requirement must minimally have Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred.
Parent Education	Provided to parents using evaluated/evidence-based practice group models that promote nurturing parenting attitudes and skills, teaching developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development, and to remediate problem behaviors. For specific group models of Parent Education, a parent with lived experience may be trained in the model and work in partnership with the Child Mental Health Professional who is trained in the delivery of the Parent Education model. Provider qualifications: ▪ Child Mental Health Professional who is trained in the evaluated/evidence-based practice group model. ▪ Parent with lived experience who is trained in the model and works with the Child Mental Health Professional in the delivery of the model. **(text revised/added 4/1/2025)**

3.25 Speech, Hearing, and Language

Evaluation	Therapy
Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.	Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO). Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided. Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage. Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.

3.26 Substance Abuse

Refer to the Substance Abuse Services Section of this chapter for specific program requirements relating to substance abuse services.

3.27 Targeted Case Management

Refer to the Targeted Case Management Section of this chapter for specific program requirements.

3.28 Telemedicine

A CMH/PIHP can be either an originating or distant site for telemedicine services. Practitioners must meet the provider qualifications for the covered service provided via telemedicine.

Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.29 TRANSPORTATION

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/1915(i) SPA service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to Healthy Kids Dental, substance abuse, and mental health services (except those noted above and in the HSW program described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local MDHHS office or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., MDHHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.30 TREATMENT PLANNING

Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. Individuals who receive specialty behavioral health supports and services have the right to choose an independent facilitator (IF) to facilitate the person-centered planning (PCP) process that is used to develop the Individual Plan of Service (IPOS). This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the IPOS, including specific services when not performed by the case manager or supports coordinator, is included in this coverage. For children and youth, a family-driven, youth-guided planning process should be utilized.

Case managers and supports coordinators perform these functions as part of the case management and supports coordination services; therefore, they should not report this activity as "Treatment Planning." Other mental health and health professionals who attend the beneficiary's person-centered planning should report the activity as "Treatment Planning."

For the Children's Waiver, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management coverage.

3.31 Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents [Title Revised & Changes Made 4/1/2025]

ICCW is an evidence-informed approach to ensuring comprehensive coordination and holistic planning for children, youth, young adults, and their families with the most intensive needs. ICCW is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children, youth, and young adults under 21 years of age.

ICCW requires the development of a Wraparound Team. The Team must be coordinated prior to the development of and adjustments to the Wraparound Plan. Wraparound Teams include, but are not limited to, the youth, child, or young adult and their family, natural supports, professional supports, and community partners. In the limited circumstance in which a child, youth, young adult, or parent/caregiver is unable to attend a Wraparound Team meeting, Care Coordinators are responsible for ensuring voice and choice.

When a child, youth, or young adult is being served under the Waiver for Children with Serious Emotional Disturbances (SEDW), ICCW is recommended to support the child, youth, young adult and their family through the planning process. At the preference of the child/youth, young adult and their family, Targeted Case Management (TCM) may be utilized instead of ICCW.

Care Coordination includes organization, coordination, linkage, monitoring of services and supports, and advocacy on behalf of the child, youth, or young adult and their family. Coordination and collaboration span across multiple systems, programs, and resources in alignment with systems of care philosophy. Wraparound is the individualized, family-driven and youth-guided planning process facilitated by Care Coordinators that are trained and certified in the Wraparound Planning Process.

The Wraparound Planning Process follows four stages: 1) Hello-Engagement and Team preparation, 2) Help-Initial plan development, 3) Heal-Implementation, and 4) Hope-Transition. The Wraparound Planning Process utilizes a collaborative Wraparound Team approach including a child, youth, or young adult and their family and their choice of professional and natural supports. Care Coordinators facilitate the Wraparound plan development, considering all life domains. **(text revised/added per bulletin MMP 24-41)**

The Child and Family Team's plan is built on strengths and driven by underlying needs. The plan provides realistic strategies to meet meaningful, measurable and attainable outcomes that the Child and Family Team develop. Ongoing evaluation of the Child and Family Team's plan occurs during each Child and Family Team meeting and adjustments are made as needed.

Children, youth, or young adults, birth to age 21, are eligible for ICCW if they meet all the following criteria:

- Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability;
- Presenting with complex behavioral needs; and
- Have an identified community.

AND two or more of the criteria listed below:

- Currently in or at risk of out-of-home placement.

- Involved in two or more child, youth, or young adult-serving systems, including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other school support services).
- Has received other case management or case management-like services, and higher intensity is required to meet needs.
- Lack of an identified support system.
- Presenting with complex medical needs and stabilization has not been reached.
- Has a functional impairment related to school activities, attendance, or performance. This includes, but is not limited to, experiencing multiple suspensions and/or expulsions.
- Displays significant physical and/or emotional distress after experiencing a traumatic event. Traumatic events may include, but are not limited to, natural disasters, acts of violence, abuse, neglect.

TCM cannot be authorized in the Individual Plan of Service (IPOS) when ICCW is authorized in the IPOS. Home-based services and ICCW may be authorized concurrently. Case-management functions performed through home-based services may not be billed at the same, specific date/time that ICCW is also being billed to avoid same-time duplication of services. **(text revised/added per bulletin MMP 24-41)**

3.31.A. Organizational Structure [Changes Made 4/1/2025]

The required organizational structure of Wraparound ICCW must include a Child and Family Team, ICCW Care Coordinator, ICCW supervisor, and Community Team.

- ICCW Care Coordinator Caseload Ratio (dedicated caseload):
  - 1:12 Care Coordinator to Wraparound Teams.
  - The dedicated ratio may increase to a maximum of 1:15 when at least three Wraparound Teams are in the Hope phase.
  - Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
  - If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.
- ICCW providers must request approval to provide ICCW from MDHHS through a certification process defined by MDHHS, and certification must occur every three years. Programs must be certified to ensure adherence to Medicaid policy requirements and fidelity to the ICCW model. **(text revised/added per bulletin MMP 24-41)**

3.31.B. Qualified Staff [Changes Made 4/1/2025]

ICCW Care Coordinators must:

- Possess a minimum of a bachelor's degree in any field.

- Receive certification in ICCW through MDHHS-provided training or have been granted provisional approval prior to provision.
- Maintain certification in ICCW:
  - Complete one annual ICCW booster.
  - Complete at least two MDHHS-provided trainings related to ICCW.
  - Complete an additional 16 hours of training (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW to those served under the SEDW.
- Participate in and complete MDHHS-required evaluation and fidelity measurements.
- Provide full scope of ICCW and facilitate the Wraparound Planning Process to model fidelity to develop a Wraparound Plan.
- Participate in Person-Centered Planning Process training, including Self Determination.
- Facilitate the Person-Centered Planning Process in alignment with family-driven and youth-guided guidelines in adherence to applicable policy to develop an Individual Plan of Service (IPOS).
- Obtain certification in MichiCANS if responsible for the completion of the annual MichiCANS.
- Demonstrate knowledge of State Plan and SEDW service array and community resources and programs.
- Attend Community Team meetings as needed to support their Wraparound Teams.
- Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.
- If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.

ICCW supervisors shall:

- Oversee ICCW, including evaluation.
- Receive/process referrals and assign children, youth, or young adults and their families to Care Coordinators.
- Adhere to policies/procedures that align with ICCW.
- Organize and facilitate Community Team meetings quarterly, at minimum.
- Be designated as a Child Mental Health Professional (CMHP) (when overseeing provision to SED youth) and/or Qualified Intellectual Disabilities Professional (QIDP) (when overseeing provision to Intellectual/Developmental Disabilities [I/DD] youth).
- Participate in Person-Centered Planning Process training, including Self Determination.
- Obtain certification in MichiCANS if providing supervision to a Care Coordinator who is responsible for completion of the annual MichiCANS.

- Receive certification in ICCW through MDHHS-provided training prior to supervision of Care Coordinators.
- Maintain certification in ICCW:
  - Complete one annual ICCW booster.
  - Complete at least two MDHHS-provided trainings related to ICCW, one of which must be supervisor specific.
  - Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families when supervising the provision of ICCW to those served under the SEDW.
- Provide weekly, individualized supervision and coaching to Care Coordinators and maintain a supervision log.
- Maintain partnership with child, youth, or young adult and family community programs, systems, and partners.
- Ensure Care Coordinators have knowledge of State Plan and SEDW service array and community resources and programs.
- Ensure families and staff have access to a directory of community resources, systems, and programs.

ICCW Program Administrators shall:

- Attend ICCW 101 Training.
- Attend one annual ICCW booster.
- Provide direct oversight of ICCW Supervisors.
- Provide local oversight of ICCW.
- Align internal policies and procedures, contracts and/or memorandums of understanding with Wraparound philosophy and ICCW policy.
- Broker services as needed.
- Secure local partnership with child, youth, or young adult and family community programs, systems and partners.

The Community Team shall:

- Include children, youth, young adults and parents/caregivers with lived experience and local system and community partners.
- Work collaboratively to address barriers, provide support, and identify available community services and programs for children, youth, and families. **(revised per bulletin MMP 24-41)**

3.31.C. Amount and Scope of Service [Changes Made 4/1/2025]

Amount of Service:

- Wraparound Teams shall meet once per week, at minimum, during the Hello and Help phases.
- Wraparound Teams shall meet twice monthly, at minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the Team agrees stabilization has been achieved.
- Wraparound Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the Team agrees that the child, youth, or young adult and family are ready to graduate from the Wraparound Planning Process and no longer show a need for ICCW.
- When a child, youth, or young adult is in placement and the Care Coordinator is facilitating transition planning back to the home and community, the meeting frequency may reflect the needs of the child, youth, or young adult. Only upon Wraparound Plan development or adjustment may the frequency of Team meetings decrease.
  - ➢ Upon discharge, frequency of meetings should align with the phase that the Wraparound Team is in.
- The Care Coordinator must review services at intervals defined in the Individual Plan of Service (IPOS). A formal review of the IPOS shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
- Frequency and scope (face-to-face and telephone) of other ICCW monitoring activities must reflect the intensity of the child, youth or young adult's health and welfare needs.

Scope of Service:

- Ensure child, youth, or young adult and their family understand the ICCW and the Wraparound Planning Process. When SEDW is being utilized, orient child, youth, or young adult and their family to the SEDW process and service array.
- Ensure documentation from other service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) involved with the child, youth, or young adult and their family is available and utilized to support identified needs.
- Coordinate communication among service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) who are involved with the child, youth, or young adult and their family.
- Ensure child, youth, or young adult and their family are linked to relevant supports, community service providers and systems partners to expand support network and address identified needs.
- Support and empower the Wraparound Team to advocate on behalf of the child, youth, or young adult and family.

- Ensure child, youth, or young adult and their family and Wraparound Team have access to informational material that supports the ability to address identified needs (guidance on navigation of specific services or systems, psychoeducation materials, parent education materials, etc.).
- Ensure Intake has been completed or is scheduled to be completed.
- Ensure service provider is providing all medically necessary services that the child, youth, or young adult and their family choose and taking appropriate action when those services are unavailable.
- Facilitate the brokerage of services and supports as identified through the Wraparound Planning Process.
- Ensure Family-Driven, Youth-Guided Process is included to develop the IPOS.
- Utilize the Wraparound Planning Process to ensure successful transition of the child, youth, or young adult back into their home and community.
- Facilitate the Wraparound Planning Process with model fidelity to the MDHHS model to develop and update the Wraparound Plan as needed or required.
- Facilitate the Family-Driven, Youth-Guided Process to develop and complete annual updates to the IPOS.
- Ensure an annual MichiCANS is completed by the appropriate entity. **(revised per bulletin MMP 24-41)**

3.31.D. Location

3.31.D.1. Telemedicine [Change Made 4/1/2025]

- **(text deleted per bulletin MMP 24-41)**
- All Child and Family Team meetings are to be provided in-person during the Hello and Help phases.
- Child and Family Team meetings may be provided either in-person or via simultaneous audio/visual telemedicine during the Heal and Hope phases, according to the preference of the child/youth and their parents/primary caregivers, with the following exceptions:
  - Development of the transition plan (Hope phase) is to be completed in-person.
  - Graduation activities (Hope phase) are to be completed in-person.
  - Child and Family Team meetings are to be provided in-person for the first 60 days upon a child/youth transitioning back to their home and community from out-of-home placement.
  - In-person Child and Family Team meetings are to be provided once per month, at minimum, for children/youth served under the SEDW during both the Heal and Hope phases.

3.31.D.2. Child Caring Institutions (CCI) and State Hospitals [Changes Made 4/1/2025]

- ICCW is covered by Medicaid for up to 180 days while in placement for the purpose of transition back to the community; Wraparound must be suspended once the child/youth has been placed for more than 180 days. When Wraparound-enrolled children/youth are placed at a CCI, including a Qualified Residential Treatment Program (QRTP), or State Hospitals, transition planning should begin immediately in conjunction with the Wraparound Child and Family Team and facility staff.
  - A child, youth, or young adult who meets eligibility criteria for ICCW should be referred to the service planning provider in the community in which they reside.
  - The Care Coordinator will work with the child/youth and their caregiver(s) to develop a Child and Family Team. The Child and Family Team will work collaboratively with facility staff and other child-serving systems to facilitate a comprehensive and holistic plan of services and supports that will enable the child/youth to return to their community.
- The child/youth must have an identified community to transition. **(revised per bulletin MMP 24-41)**
- Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

Refer to the Program Requirements section, Location of Services subsection of this chapter for additional information regarding provision within a CCI and State Hospital. **(revised 4/1/2025)**

3.31.E. Child and Family Team Plan and Wraparound Planning Process [Changes Made 4/1/2025]

The Wraparound Planning Process must be provided with fidelity in accordance with the MDHHS ICCW model. The Person-Centered Planning Process must be provided according to MDHHS policy, including Family Driven and Youth Guided policy.

The Safety/Crisis Plan, Wraparound Plan and the Individual Plan of Service (IPOS) are the resulting plans from the utilization of the Wraparound Planning Process and the Person-Centered Planning Process. The Wraparound plan should drive development and/or adjustment of the IPOS.

The following planning process activities and supporting documentation shall be completed for each child/youth and family:

Safety/Crisis Plan	▪ Safety/Crisis Plans must be developed upon the initial meeting with the child, youth, or young adult and their family. ▪ Existing Safety/Crisis Plans are to be reviewed with the child, youth, or young adult and their family following initial utilization and as needed to determine if modifications are necessary. ▪ Safety/Crisis plans must be developed with fidelity to the MDHHS Wraround model.

Wraparound Plan	▪ The Wraparound Plan must be developed within 30 days of initial service provision. ▪ The Wraparound Plan's strategies are to be reviewed at each Team meeting, and Team adjustments to strategies are to be completed by the Care Coordinator. ▪ The Wraparound Plan's outcomes are to be reviewed at least monthly, and Team adjustments to the Plan are to be completed by the Care Coordinator. ▪ Wraparound Plan elements must be developed with fidelity to the MDHHS Wraparound model to ensure fidelity.
Individual Plan of Services (IPOS)	▪ The IPOS Pre-Plan must be developed in the Wraparound Team meeting during the Hello phase. ➢ The annual IPOS Pre-Plan must be developed within the Wraparound Team meeting. ▪ The IPOS must be developed in the Help phase following development of the Wraparound Plan. If there is an existing IPOS, it must be updated to reflect the newly developed Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention. ▪ The annual IPOS must be developed within the Wraparound Team meeting, driven by the existing Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention. ▪ IPOS elements must comply with Michigan Administrative Code R330.7199 requirements.
Wraparound Team Meeting Minutes	▪ Meeting minutes must be developed following each Wraparound Team meeting and distributed to all Wraparound Team members. ▪ Meeting minutes elements must comply with documentation requirements for MDHHS Wraparound model fidelity monitoring.
Graduation Summary	▪ The Graduation summary must be completed within the last month of the Hope phase and distributed to the child, youth, or young adult, and their family. ▪ The Graduation summary elements must be developed with fidelity to the MDHHS Wraparound model. **(revised per bulletin MMP 24-41)**

3.31.F. Evaluation and Outcomes Measurement [Changes Made 4/1/2025]

The enrolled provider will comply with the State of Michigan ICCW evaluation requirements. Current evaluation requirements are:

- The enrolled ICCW provider will comply with MDHHS ICCW evaluation requirements as determined by the department.
- Additional evaluation tools will be completed as identified and requested by MDHHS.
- Adherence to ICCW model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools. **(revised per bulletin MMP 24-41)**

SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources (such as food, housing, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-days-per-week crisis availability provided by the multi-disciplinary ACT team which includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team staff.

The Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDHHS and meet the program components outlined below. Provider programs with more than one ACT team must have individually approved and registered ACT teams. All ACT teams are subject to MDHHS re-approval every three years.

4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary diagnosis of serious mental illness and who, without ACT, would require more restrictive services and/or settings. ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual or developmental disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality disorder or co-occurring Substance Use Disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. Areas of impairment are significant and are considered individually for each beneficiary.

These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends;
- Accessing needed mental health and physical health care;
- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens;
- Performing activities of daily living or other life skills;
- Managing medications without ongoing support;
- Maintaining housing;
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison;
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
- Maintaining recovery to meet the challenges of a co-occurring Substance Use Disorder;
- Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services.

4.3 ESSENTIAL ELEMENTS [CHANGE MADE 7/1/2025]

Team-Based Service Delivery	ACT is a team-based behavioral health service that includes shared service delivery responsibility that provides consistent continuity of care. Case/care management, psychiatric services, counseling/psychotherapy, peer support services, housing support, substance use disorder treatment, employment and rehabilitative services are interwoven with treatment and rehabilitative services, and services are provided by all members of the ACT team in the beneficiary's home or community. All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-approved ACT-specific training annually thereafter. All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists must participate in the MDHHS-approved Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists training one time, with additional ACT training/participation for Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists encouraged, but not mandatory. Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians, Nurse Practitioners, Physician's Assistants or Clinical Nurse Specialists are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case/care management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community.

	A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed upon community location. Treatment groups identified in the Individual Plan of Service (IPOS), such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held. The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts.
Team Composition and Size *A minimum of 80% of ACT contacts provided by the team are in the beneficiary's home or other agreed-upon community location.* *The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to a consumer will comprise 80% of home or community contacts. This average is for the entire team, an average across the entire caseload (not individual consumers) and is to be*	All ACT team members, including the team leader, perform all team functions for which they are qualified. An ACT team member's individual scope of service allows for variance in the frequency of community contacts, and responsibility for primary caseload responsibilities; beneficiary assessment, after hours crisis coverage, person-centered planning and development of individual plans of service, while not exclusive, are examples of activities all team members perform and share. The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. The minimum ACT staffing requirements are below. An ACT team operates minimally with 4 FTE staff and with no more than 9 FTE staff members. Teams average 6-7 FTE staff. If an ACT team believes it is necessary to operate outside of team requirements, consult with MDHHS regarding feasibility. If appropriate, a waiver request may be submitted to the PIHP. If approved, the PIHP will submit the request to MDHHS for consideration of approval. ▪ A full-time team leader whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness and minimally possesses a master's degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The ACT team leader also meets the requirements of a MHP and licensing requirements in accordance with Licensing and Regulatory Affairs (LARA) for their position description and provider qualifications. **(revised 7/1/2025)** ▪ A full-time registered nurse (RN) is required on the ACT team. The RN provides integrated behavioral and physical healthcare, including managing medication, assessing and coordinating physical/medical care, and providing direct services to the beneficiary in the community. A physician who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner, physician's assistant or clinical nurse specialist, but the nurse practitioner, physician's assistant or clinical nurse specialist must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telemedicine. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration.

Telemedicine is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in person. The telemedicine modifier must be used in conjunction with the ACT encounter reporting code when telemedicine is used. *All telemedicine interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner/physician's assistant/clinical nurse specialist from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.* *Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements and the Telemedicine chapter for additional telemedicine requirements.*	▪ A physician assistant may perform clinical tasks under the terms of a practice agreement with a participating physician. The physician assistant must hold a current physician assistant license and a controlled substance license in Michigan. The physician assistant is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, physician assistant activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telemedicine. ▪ A nurse practitioner or clinical nurse specialist may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner/clinical nurse specialist must hold a specialty certification as a nurse practitioner/clinical nurse specialist in Michigan, a current license to practice nursing in Michigan, and a master's degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner/clinical nurse specialist, they may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner/clinical nurse specialist is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner/clinical nurse specialist activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telemedicine. ▪ A case or care manager, possessing minimally a bachelor's degree in a human services discipline, who possesses appropriate licensure to provide the core elements of case or care management with at least one year of experience providing services to adults with a mental illness, and is a QMHP. If the case or care manager has a bachelor's degree but is without one year of experience working with adults with serious mental illness or co-occurring disorders and otherwise meets the requirements of the QMHP, documentation of clinical supervision is provided in the beneficiary record. ▪ Individual/family/group counseling provided by a MHP, including a limited-licensed master's degree social worker who is supervised by a licensed master's degree social worker. ▪ Up to one Full Time Equivalent (FTE) Peer Support Specialist (PSS) may substitute for one QMHP to achieve the 1:10 required staff-to-beneficiary ratio. Under the supervision of the ACT team leader, a PSS may provide documentation in beneficiary records. This supervision is documented in the beneficiary record. PSSs are individuals with a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption. The Centers for Medicare & Medicaid Services (CMS) requires that PSSs must be supervised by a Qualified Mental Health Professional (QMHP) as defined by the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA). The amount, duration and scope of supervision can vary depending on the demonstrated competency and experience of the PSS and may range from direct oversight to periodic care consultation in accordance with their position description and provider qualifications. ▪ Up to one FTE paraprofessional staff to work with ACT teams may be counted in the staff-to-beneficiary ratio. Paraprofessional staff may have a bachelor's degree or related training in a field other than behavioral sciences (e.g., certified occupational therapy assistance, home health care); or have a high school equivalency and work or life experience with adults with severe mental illness or co-occurring substance use disorders.

Treatment Groups identified in the IPOS, such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held. *The scope of services for individual ACT staff members require that some staff will work in the community more often than others.*	▪ If the ACT team provides substance use disorder services, there must be a designated Substance Abuse Treatment Specialist who has one or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance use disorder treatment, the organization must have a substance use disorder treatment license issued by the State of Michigan, if applicable, based on state licensing requirements and as outlined in contract. Additional staff positions reflect the needs of the population, such as the ability to obtain housing, employment services and rehabilitative services for beneficiaries who request them, and shall minimally be a QMHP.
Staff-to-Beneficiary Ratio	The ACT team's staff-to-beneficiary ratio shall be at least one FTE ACT staff to a maximum of 10 ACT beneficiaries, a 1:10 staff-to-beneficiary ratio. Teams serving large service areas, highly complex beneficiaries, or very high acuity beneficiaries may find a lower staff-to-beneficiary ratio better meets beneficiary needs and retains team capacity to quickly address emerging or acute treatment needs and adjust service contacts. With the exceptions of the limitations on paraprofessionals and certified peer support specialists described above, the staff ratio includes all ACT team members, excluding the clerical support staff and physicians, nurse practitioners, physician assistants, and clinical nurse specialists.
Fixed Point of Responsibility *Provision of ACT service; place of service is indicated as hospital. For specific codes and modifiers, refer to the Behavioral Health Code Chart and Provider Qualifications document on the MDHHS website for details. (Refer to the Directory Appendix for website information.)*	The ACT team is the fixed point of responsibility for the development of the individual plan of service (IPOS) using the person-centered planning process and for supporting beneficiaries in all aspects of community living. The process addresses all services and supports to be provided to or obtained for the beneficiary by the team, including consultation with other disciplines and/or coordination of other supportive services as appropriate. Care continuity is maintained with pre-admission screening, team contact during inpatient psychiatric hospitalizations, and team participation in transition and discharge planning.

Availability of Services *Pre-admission screens for ACT beneficiaries must be reported by including the appropriate modifier with the ACT encounter code. For specific codes and modifiers, refer to the Behavioral Health Code Chart and Provider Qualifications document on the MDHHS website for details. (Refer to the Directory Appendix for website information.)*	Availability of ACT services must include: ▪ 24-hour/7-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. ▪ The ACT team is responsible for performing the required pre-admission screen for all beneficiaries certified in an ACT program seeking inpatient psychiatric admission. ▪ The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries in acute need or with emergent conditions. ▪ The ACT team has the ability to provide needed services to the beneficiary 7 days a week as per the IPOS.
Individual Plan of Service (IPOS)	ACT services and interventions must be consistent and balanced through medical necessity and the preferences of the beneficiary while embracing person-centered principles, wellness and behavioral health recovery with a goal of maximizing independence and a progression into less intensive services. Beneficiaries with co-occurring substance use disorders must have both behavioral health and substance use disorders addressed in the IPOS. Beneficiaries who need a less intensive service than ACT, such as case/care management, have documentation in the IPOS detailing the transition plan to the new service and a plan to return to ACT should the need occur.
In Vivo Settings	ACT teams provide a wide array of clinical, medical and rehabilitative services during face-to-face interactions designed to promote the beneficiary's growth in recovery. ACT services and supports are focused on acquiring needed behavioral health services, substance misuse services, physical health care, performing activities of daily living, obtaining and/or maintaining employment, developing leisure activities, developing and maintaining meaningful relationships, maintaining housing, avoiding arrest and incarceration, navigating the legal system, transitioning successfully into the community from jail or prison, and relapse prevention. Services for ACT beneficiaries may include those defined elsewhere in this chapter, as well as others that are consistent with individual preferences, professionally accepted standards of care, and that are medically necessary. ACT services may be used as an alternative to hospitalization as long as beneficiary health and safety issues can be reasonably well-managed with ACT supports that do not require 24-hour-per-day supervision.

4.4 Eligibility Criteria

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary's existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization or intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.

The ACT acute service selection guideline covers criteria in the following domains:

Diagnosis	The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness	Psychiatric Status ▪ Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions, ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions, rituals, impaired reality testing and/or impairments in functioning and role performance. Self-Care/Independent Functioning ▪ Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational/parental role performance expectations. ▪ Drug/Medication Conditions - Drug/medication adherence and/or a co-existing general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions. ▪ Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the beneficiary or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.

Intensity of Service	ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and /or allow the beneficiary to function without more restrictive care, and the beneficiary requires at least one of the following: ▪ An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery. ▪ The beneficiary's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression and forestall the need for inpatient care in a 24-hour protective environment. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports. ▪ Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations. ▪ Frequent monitoring of medication regimen and response is necessary and adherence is doubtful without ongoing monitoring and support. ▪ Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects. ▪ The total number of contacts averages 120 minutes of face-to-face time each week for each beneficiary. Higher frequency with shorter visits is most effective and is determined and adjusted as needed within the flexibility identified in the Individual Plan of Service (IPOS) and case notes. Clearly documented clinical rationale is provided in exception cases where an average of 120 minutes for each beneficiary is clinically inappropriate.

Discharge *For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management.*	Cessation or control of symptoms is not sufficient for discharge from ACT. For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person-centered planning process as described below: ▪ The beneficiary no longer meets severity-of-illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to show clinical stability. Beneficiaries who meet medical-necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program. If a beneficiary requests transition to other service(s) because they believe maximum benefit has been reached in ACT, consideration for transition into less intensive services must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for re-certification into ACT services, if needed. ▪ Engagement of the beneficiary in ACT is not possible as deliberate, persistent and frequent assertive team outreach, including face-to-face engagement attempts and legal mechanisms when necessary, have been consistent, unsuccessful, and documented over many months, and an appropriate alternative plan has been established with the beneficiary. ▪ Beneficiary has moved outside of the geographic service area. Contact continues until service has been established in the new location.

SECTION 5 – CLUBHOUSE MODEL PROGRAMS

A Clubhouse is a community-based program organized to support individuals living with mental illness. Participants are known as Clubhouse members, and member choice is a key feature of the model. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where empowerment, relationship-building, skill development and related competencies are gained. Through what is referred to as the work-ordered day, the Clubhouse provides opportunities for member involvement and ownership in all areas of Clubhouse operation. Members and staff work side-by-side in the program as colleagues. Comprehensive opportunities are provided within the Clubhouse, including supports and services related to employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. In addition, members participate in the day-to-day decision-making and governance of the program. Through Clubhouse involvement, members achieve or regain the confidence and skills necessary to lead satisfying, meaningful lives and successfully manage their mental illness. The Clubhouse model is included in the National Registry of Evidence-based Programs and Practices (NREPP), which can be found on the NREPP website. (Refer to the Directory Appendix for website information.)

5.1 PROGRAM APPROVAL

- PIHPs must seek approval for providers of Clubhouse services from the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA).
- To ensure fidelity to the model of the evidence-based practice of Psychosocial Rehabilitation, Clubhouses must acquire and maintain Clubhouse International accreditation. Additional information regarding Clubhouse International accreditation is available on the International Center for Clubhouse Development (ICCD) website. (Refer to the Directory Appendix for website information.)
- All new Clubhouses must participate in the Clubhouse International's New Clubhouse Development Training.
- MDHHS approval will be based on adherence to the requirements outlined below.

Requests for approval of Clubhouse services may be submitted to the MDHHS-BPHASA Community Based Practices and Innovation Section, Division of Adult Home and Community Based Services. (Refer to the Directory Appendix for contact information.)

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured community with staff and peers and who desire to work on the goal areas reflected in the Core Psychiatric Rehabilitation Components subsection of this document. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members.

5.3 Essential Elements of the Clubhouse Model

Member Choice/ Involvement	Member choice and involvement are an ongoing essential process imbedded in all aspects of the Clubhouse model. ▪ Membership is voluntary. ▪ Clubhouse Membership is without time-limits; access to an intentional community supports the recovery process. ▪ All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning. ▪ Members establish their own schedule of attendance and choose a work unit that they will regularly participate in during the work-ordered day. ▪ Members are actively engaged and supported on a regular basis by Clubhouse staff in the activities and tasks that they have chosen. ▪ Membership in the program and access to supportive services reflects the beneficiary's preferences and needs, building on the person-centered planning process. ▪ Both formal and informal decision-making opportunities are part of the Clubhouse work units and program structures. Members can influence and shape program operations. Clubhouse decisions are generally made by consensus. ▪ Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.
Work-Ordered Day	▪ The work-ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It consists of tasks and activities necessary for the operation of the Clubhouse and typically occurs during normal business hours. ▪ Although participation in the work-ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. ▪ Member participation in the work-ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems. ▪ The program's structure and schedule identifies when the various program components occur (e.g., work-ordered day, vocational/educational). Other activities, such as self-help groups and social activities, are scheduled before or after the work-ordered day. ▪ The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems. ▪ The amount, scope, and variety of tasks are sufficient enough to engage the membership in meaningful activities throughout the work-ordered day.

	▪ All staff are Clubhouse generalists. Their responsibilities are housed in a unit and they routinely work side-by-side with members to complete unit work. ▪ Staff help to identify meaningful work opportunities for members and are able to facilitate workgroups. ▪ Staff are dynamic and skilled at developing relationships with members. Staff utilizes a strengths-based approach and promotes an equal culture with members, thereby allowing members to experience themselves as valued colleagues in the Clubhouse community.
Employment Services	▪ The Clubhouse provides its own employment services, including Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE), consistent with Clubhouse International standards and guidelines, which are available on the ICCD website. (Refer to the Directory Appendix for website information.) ▪ Additional resources for benefits planning are available.
Educational Services	• The Clubhouse provides resources and connections to assist members with goals to return to formal educational settings. This should include some of the following supports: ➢ connections with local colleges and General Educational Development (GED) centers, ➢ assistance with admission and financial aid applications, ➢ tutoring assistance with fellow members when appropriate, ➢ formal education groups, and ➢ other activities that support member success. Educational programming should be individualized and should enhance the Clubhouse work-ordered day.
Community Supports	• Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse and include outreach, entitlements, housing, advocacy, promoting wellness, as well as assistance in finding quality medical, psychological, pharmacological and substance use disorder treatment services in the community. • The Clubhouse has an advisory board that meets regularly to provide support. Advisory board composition includes individuals from the local community who are able to assist with connections and/or advice in areas such as employment, education, legal assistance, finances, and advocacy. The board also includes member leaders. • The Clubhouse must engage with the local community. Activities may include speaking engagements, connections with media outlets, awareness-raising, political advocacy, community service projects, open houses, participating with the statewide Clubhouse coalition, and relevant conferences. ▪ The Clubhouse ensures that access to the building, Clubhouse-sponsored community activities, and employment sites are available through public transportation or other alternative modes of transportation. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

Social Supports	• Opportunities are available for members to develop a sense of a community through planning and organizing Clubhouse social activities. This may include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities. ▪ Members may have access to the Clubhouse programming during times other than the work-ordered day, including evenings, weekends, and holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day). Access during these times should be based on the needs of the Clubhouse community and decided by members and staff.
Wellness Supports	▪ The Clubhouse supports and encourages physical wellness. This may include enhanced nutrition, weight loss, exercise, smoking cessation, and promoting wellness throughout the Clubhouse. Wellness opportunities occur both within the Clubhouse and through connections with community resources. ▪ The voluntary nature of the Clubhouse is respected for all wellness activities. Wellness programming should enhance the Clubhouse work-ordered day rather than detract from it.
Community Setting	▪ The program is designed as an intentional community, rather than a clinical setting. The Clubhouse does not include clinical personnel such as psychiatrists, nurses, or therapists, nor does it include classes or groups that are of a clinical nature. ▪ The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity. ▪ To promote pride and ownership, the Clubhouse has its own identity, including its own name, mailing address, fax, e-mail, and telephone number. ▪ All Clubhouse space is member and staff accessible. There are no staff-only or members-only spaces. ▪ There are no staff-only or members-only meetings where program decisions are made.

5.4 Core Psychiatric Rehabilitation Components

The Clubhouse model is not limited to a narrow set of components. A broad contextual perspective is present throughout the Model.

Broad Context	▪ The Clubhouse model is embedded in the overarching goals of psychiatric rehabilitation. The aims and objectives of Clubhouse communities are to support the access to preferred living, learning, working, and socialization roles for members in their communities. ▪ Outcomes that move beyond the clinical condition and facilitate the recovery process from mental illness are more relevant, such as social role functioning (e.g., meaningful roles in society; social inclusion), establishing relationships, social support networks and social capital, work, recreation, and improved quality of life.

Personal Goal Development	Each Clubhouse member has goals based on their Individual Plan of Service (IPS) developed through the Person-Centered planning process and carried out throughout the member's participation in the Clubhouse. Staff may also work informally with members on individual recovery goals while working side-by-side in the Clubhouse.
Psychiatric Rehabilitation Components, Goals and Objectives	Clubhouse environments support recovery in a variety of ways. Generally, expected outcomes associated with accredited Clubhouse participation include greater personal and interpersonal competencies, links with community resources, access to social support networks, increased illness and symptom management, vocational and educational competencies and opportunities, and overall increased personal independence and psychosocial functioning. • Competency Building Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment) are built and include: ➢ Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining positive self-image, interpersonal problem-solving, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships). ➢ Personal adjustment competencies (e.g., developing and enhancing intrapersonal abilities and problem-solving in everyday experiences, resolving crises, or managing stress with the goal of facilitating self-efficacy and personal independence). ➢ Vocational competencies (e.g., focused tasks that teach how to apply for jobs, conduct employment interviews, provide opportunities of graded steps to promote job entry or reentry, improve co-worker communication and relationships, and task focus and completion). ➢ Cognitive competency (e.g., task-oriented activities to develop and maintain cognitive abilities, maximize independent functioning such as increased attention, improved concentration, better memory, and enhanced empathy). • Community Support, Inclusion, and Participation Identification of support, inclusion and participation through existing natural supports is necessary to: ➢ Achieve optimal levels of community membership. ➢ Increase satisfaction with living environment. ➢ Support community participation and integration/inclusion. ➢ Reduce stigma through education, community awareness, and community networking. ➢ Facilitate social capital via peer and social networks, both internal and external to Clubhouse. ➢ Promote utilization of organizational support, community resources, and other collateral support systems, as well as linking with community resources, supports, and services for continuity of care.

	▪ Illness Management and Recovery The identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychiatric relapses include the following: ➢ Gaining competence regarding how to respond to and manage a psychiatric crisis (includes working in partnership with members who express desire to develop a recovery plan and incorporate natural supports in crisis planning). ➢ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well-being or recovery. ➢ Working in partnership to increase confidence and personal self-efficacy through Clubhouse participation. ➢ Gaining access to holistic approaches to recovery that includes education, information and support for health and personal wellness. ➢ Gaining access to information to support decision making and increased empowerment through Clubhouse participation. • Recovery Enhancing Environment An environment that fosters strength and resilience and practices the inclusion of the following: ➢ Is collaborative and non-hierarchical; ➢ Supports work and high levels of activity; ➢ Respects choice and control; and ➢ Provides access to social and peer support.

5.5 Documentation

Documentation of members' progress in the Clubhouse modality differs from documentation requirements in individual treatment modalities and is demonstrated in the following process.

- Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis.
- The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day.
- Progress note processing should be integrated into unit work.
- Members have the opportunity to write their own progress notes.
- Generally, all notes should be signed by both members and staff.

5.6 Eligibility

Clubhouse services are intended for beneficiaries with a primary diagnosis of serious mental illness. Clubhouse is not an appropriate service for beneficiaries with a primary intellectual/developmental disability.

Clubhouse services are not appropriate for beneficiaries who exhibit:

- Behaviors that would threaten or pose a current health and safety risk to themselves or others.
- A severity of symptoms requiring a more intensive level of treatment.
- Behaviors that disrupt the daily work of the Clubhouse.
- Behaviors that require excessive redirection and/or monitoring.

The Clubhouse director has the responsibility to ensure the safety of the Clubhouse.

All changes to a member's service provision must follow due process and all policies and procedures at local, state, and federal levels.

Discharge criteria are only met if the member moves on voluntarily or if one or more of the above criteria are met. Cessation or control of symptoms alone is not sufficient criteria for discharge from the Clubhouse.

5.7 Staff Capacity

Clubhouse staff effectively facilitate the program with direct, inclusive and collegial member involvement. Sufficient staffing ratios allow for employment development, Transitional Employment management/coverage, supported education, and consistent engagement of the membership throughout the work-ordered day.

Clubhouse staff shall include:

- One full-time on-site Clubhouse director who has a minimum of:
  - A bachelor's degree in a health or human services field and is licensed, certified or registered by the State of Michigan or a national organization to provide health care services, with two years' experience working at a Clubhouse accredited by Clubhouse International; or
  - A master's degree in a health or human services field with appropriate licensure and one year experience working at a Clubhouse.
- Other diverse and uniquely qualified professional staff, typically with a bachelor's education level. If staff are not licensed, certified or registered by the State of Michigan or a national organization to provide health care services, they shall operate under a qualified professional.

All Clubhouse staff function as generalists sharing Clubhouse duties such as employment, social recreation, evening, weekend, and holiday coverage. All Clubhouse generalist staff should be paid at a level commensurate with like staff at the auspice agency. The Clubhouse director is responsible for all aspects of Clubhouse operations. Members are actively involved in the hiring process for both directors and generalists. Exceptions may be requested to the above staffing requirements and/or qualifications and must be submitted in writing to MDHHS for review and potential approval.

5.8 Training Requirements

All Clubhouse staff must have a basic knowledge of the Clubhouse Model acquired through MDHHS approved Clubhouse-specific training within six months of hire, and then at least one MDHHS-approved Clubhouse specific training annually. In addition, as part of the accreditation process, the Clubhouse director, members, staff and other appropriate persons participate in a comprehensive training program in the Clubhouse Model at an accredited training base. This team will also schedule a six-month follow-up site visit with the Training Base Clubhouse.

- This training requires the development of an action plan for developing the Clubhouse; and upon returning from training, all Clubhouses will submit their action plan to MDHHS.
- Exceptions may be requested to the above training requirements and must be submitted in writing to MDHHS for review and potential approval.

SECTION 6 – CRISIS RESIDENTIAL SERVICES

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

Individuals who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life including relationships, where to live, training, employment, daily activities, and physical well-being.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. The program must include on-site nursing services (RN or LPN under appropriate supervision). On-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.

6.2.B. Adult Crisis Residential Services

The program must include on-site nursing services (RN or LPN under appropriate supervision).

- For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

6.3 Provider Criteria

The PIHP must seek and maintain MDHHS approval through a certification process for the crisis residential program in order to use Medicaid funds for program services.

6.4 Qualified Staff

Treatment services must be clinically-supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone at all times. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process. Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services (refer to Covered Services subsection) must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times), by a mental health professional possessing at least a master's degree in human services and one year of experience providing services to beneficiaries with serious mental illness, or a bachelor's degree in human services and at least two years of experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing services to beneficiaries with mental illness, or who have successfully completed a PIHP/MDHHS-approved training program for working with beneficiaries with mental illness.

Peer support specialists may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentoring towards recovery.

6.5 Location of Services

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.

6.6 Admission Criteria

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

6.7 Duration of Services

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

6.8 Individual Plan of Service

Services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

The plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the activities designed to assist the beneficiary to attain their goals and objectives.
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

For children's intensive crisis residential services, the plan must also address the child's needs in context with the family's needs. Educational services must also be considered and the plan must be developed in consultation with the child's school district staff.

SECTION 7 – HOME-BASED SERVICES

Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports.

NOTE: This service is a State Plan EPSDT service when delivered to children under 21 years of age.

7.1 PROGRAM APPROVAL

Applications for certification must identify home-based providers, either internal or contractual, who will serve children under 21 years of age. Home-based services can be provided by one or more providers who serve one or more age groups. Once certified, a program must certify every three years. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based on adherence to the requirements outlined below.

Applications for certification must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDHHS must include basic program information submitted in a format prescribed by MDHHS. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDHHS or provisional approval will be withdrawn.

Organizational Structure	The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met: ▪ Enrolled home-based services providers are available and sufficient to ensure that home-based services are provided to children beginning prenatally to age 17 and meet the need across the entire catchment area. ▪ Responsibility for directing, coordinating, and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience. ▪ One staff member or a team of staff may provide these services. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families. ▪ The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/3 transitioning). ▪ If providers wish to utilize clinicians who have more than one role in the agency (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services families assigned to each partial position cannot exceed the same percentage of the maximum active home-based services families. For example, a 50% home-based position could serve no more than 6 home-based families. The total maximum number of families, including home-based and other services families, for a full-time clinician with multiple roles is 20 families. ▪ To determine the appropriate number of families for any home-based services worker, the intensity of service need presented by each family should be considered. The worker-to-family ratio can always be lower than the maximum to accommodate families with very high service needs. ▪ Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign–in sheets, or other methods of documentation. ▪ The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings. ▪ There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.

Qualified Staff	Properly credentialed staff must deliver home-based services. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services. For home-based services programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions and must minimally have Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. For home-based services programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Intellectual Disability Professional (QIDP). Trained paraprofessional assistants may assist home-based services professional staff with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under the supervision of relevant professionals. Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family. Activities of home-based services assistants do not count as part of the minimum four hours of face-to-face home-based services provided by the primary home-based services worker per month. The home-based services assistant's face-to face time would be in addition to hours provided by the primary home-based services worker.
Plan of Service	Home-based services must be provided in accordance with a plan of service that focuses on the child and their family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies through an equitable person-centered, family-driven and youth-guided planning process. The plan of service should include evidence of a blending of perspectives and information from the child/youth, family, home-based services worker, assessment tools, and other relevant parties. Goals should be based on family needs and priorities and reflect the family culture and voice. Refer to the Family-Driven and Youth-Guided Policy and Practice Guideline (attached to the MDHHS/PIHP contract) for more explicit information on this topic. The plan of service for youth receiving home-based services must also include individualized crisis and safety plans that explicitly outline responses to family-specific crisis situations and safety risks and delineate who, including the family and others, is accountable for the various responses identified.

Amount and Scope of Service	Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning and promote resilience and optimal mental health of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family. Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning and promote resilience and optimal mental health for individuals, couples, or families. A minimum of four hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service. The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months. Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or agency on-call staff. If after-hours crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provide the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.
Location of Service	Services are provided in the family home or community. Any contacts that occur other than in the home or community must be clearly explained in record documentation as to the reason, the expected duration, and the plan to address issues that are preventing the services from being provided in the home or community.

7.2 Eligibility Criteria

The criteria for home-based services are described below for children birth through age three, children age four through age six, and children age seven through age seventeen. These criteria do not preclude the provision of home-based services to an adult beneficiary prenatally or who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services when it is determined through a person-centered, family-driven and youth-guided planning process that these services are necessary to meet the needs of the child and family. For continuing eligibility reviews during the transition to less intensive services, the child and family may be maintained in home-based services, even if they do not meet these criteria. Variation from the required criteria for families transitioning out

of home-based services must be documented in the plan of service. This transition period is not to exceed three months.

7.2.A. Prenatal/Birth Through Age Three

Unique criteria must be applied to define serious emotional disturbance for the prenatal/birth through age three population, given:

- The magnitude and speed of developmental changes through pregnancy and infancy;
- The limited capacity of the very young to symptomatically present underlying disturbances;
- The extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- The exceptional vulnerability of the very young to other relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of the primary indicators of emotional disorder in very young children, and of the importance of assessing the constitutional/physiological and/or care-giving/ environmental factors which reinforce the severity and intractability of the child's disorder. Furthermore, the rapid development of very young children results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess children in the appropriate developmental context.

Refer to the MichiCANS section, Respite Care subsection, for additional information.

7.2.B. Age Four Through Five

Decisions regarding whether a child age four through five has a serious emotional disturbance and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of condition. However, as with younger children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the child's expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Refer to the MichiCANS section, Home Based Services subsection, for additional information.

7.2.C. Age 6 Through 20

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional

impairment/limitation of major life activities, and duration of the condition. For children age 6 through 20 (day prior to 21), the MichiCANS is used to make determinations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.

Refer to the MichiCANS section, Home Based Services subsection, for additional information.

SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where they reside. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDHHS and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.

Emergency Room Services	When necessary, the beneficiary may seek services through the emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP and may result in: ▪ Inpatient admission; ▪ Referral to an alternative service when appropriate and available; or ▪ Disposition of the crisis through provision of immediate services/interventions, with follow-up as necessary. The PIHP is involved in the psychiatric aspect of the emergency situation. Any medical treatment needed by the beneficiary is beyond the general purview of the PIHP.
Admissions to In-State Out-of-Area Hospitals	Medicaid beneficiaries may seek inpatient psychiatric services from hospitals located outside their county of residence/PIHP catchment area. If the out-of-area hospital has a contract with the beneficiary's county/catchment area PIHP, the hospital should contact that PIHP to obtain the required pre-admission authorization/approval for the beneficiary. If the out-of-area hospital does not have a contract with the beneficiary's designated county/catchment area PIHP, the hospital must contact the PIHP that serves the county in which the hospital is located to obtain pre-admission approval/authorization. The hospital-area PIHP will conduct the pre-admission review and will consult with the designated county/catchment area PIHP to determine the appropriate disposition of the request for admission authorization/approval. Payment responsibility for authorized days of care will rest with the PIHP that authorized the services.
Admission to Out-of-State Non-Borderland Inpatient Psychiatric Hospitals	The PIHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PIHP is responsible for continued stay reviews and payment to these hospitals.

8.2 Appeals

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or their legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, they may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

8.3 Beneficiaries Who Do Not Have Medicaid Eligibility Upon Admission

For beneficiaries whose enrollment in Medicaid is determined after the end of an episode of inpatient psychiatric or partial hospitalization care (eligibility extends back and encompasses the dates of the episode of care), the PIHP will conduct a retrospective review of the episode of care to determine if services were medically necessary and appropriate for Medicaid reimbursement, unless the PIHP has

previously reviewed and certified the admission and authorized days of care under other contractual and payment arrangements with the hospital. If the PIHP has conducted the pre-admission authorization and continuing stay reviews for these beneficiaries during the episode of care, this will be considered as a certification that authorized services are eligible for reimbursement by the PIHP under the Medicaid program once the beneficiary's retroactive Medicaid eligibility has been established.

As noted above, the purpose of a retrospective review is to determine if services rendered were medically necessary and hence qualify for Medicaid reimbursement. Since the hospital will not receive reimbursement for any care rendered which does not meet the test of medical necessity, it is advantageous for hospitals to involve PIHPs during the episode of care for any beneficiary that the facility believes may be eligible for Medicaid.

8.4 Medicare

For Medicare-covered services, the PIHP may only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles). (Refer to the Coordination of Benefits Chapter in this manual for more information.)

8.5 Eligibility Criteria

8.5.A. Inpatient Psychiatric and Partial Hospitalization Services

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that coexist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.B. Inpatient Admission Criteria: Adults

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor

retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.

- Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
- A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.

- Disruptions of Self-Care and Independent Functioning
  - The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.
  - There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations.
- Harm to Self
  - Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.
  - Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
  - Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
- Harm to Others
  - Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.
  - There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).
- Drug/Medication Complications or Coexisting General Medical Condition Requiring Care
  - There has been significant destructive behavior toward property that endangers others.

	➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. **Special Consideration: Concomitant Substance Abuse -** The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.C. Inpatient Admission Criteria: Children Through Age 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the child, youth, or young adult is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **one** of the following manifestations is present: ▪ Severe Psychiatric Signs and Symptoms ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care. ➢ Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others. ➢ Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction. ▪ Disruptions of Self-Care and Independent Functioning ➢ Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder. ➢ The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance. ▪ Harm to Self ➢ A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity. ➢ There is a specific plan to harm self with clear intent and/or lethal potential. ➢ There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts. ➢ There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior. ➢ There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations. ➢ There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder. ▪ Harm to Others ➢ Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.

	➢ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired. ➢ There has been significant destructive behavior toward property that endangers others, such as setting fires. ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. ▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. **Special Consideration: Concomitant Substance Abuse -** The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.
Intensity of Service	The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least **one** of the following: ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.D. Inpatient Psychiatric Care – Continuing Stay Criteria: Adults, Adolescents and Children

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated

medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment. ▪ Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment. ▪ Continued significant self/other harm risk. ▪ Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring. ▪ Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
Intensity of Service	▪ The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications. ▪ The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.

	▪ The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

9.1 ADULT SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure themself or another individual, either intentionally or unintentionally.
- The individual is unable to provide themself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the mental health professional, their continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

9.1.A. APPROVAL

The PIHP must seek and maintain MDHHS approval for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.1.B. POPULATION

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

9.1.C. SERVICES

Intensive crisis services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);

- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

9.1.D. Qualified Staff

Intensive crisis services must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times but must be available by telephone at all times. The treatment team providing intensive crisis stabilization services must be mental health professionals. Nursing services/consultation must be available.

The treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists.

9.1.E. Location of Services

Intensive crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, their usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

9.1.F. Individual Plan of Service

Intensive crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services treatment plan must be developed. The intensive crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.

- Identification of the services and activities designed to resolve the crisis and attain their goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

9.2 Children's Services

Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

A crisis situation means a situation in which at least one of the following applies:

- The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.
- The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.
- The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.
- The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.

The goals of intensive crisis stabilization services for children are as follows:

- To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning;
- To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth 's functioning ability;
- To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;
- To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and
- To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.

9.2.A. Approval

The PIHP must seek and receive MDHHS approval through a certification process, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.2.B. Population

These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face to face contact in one hour or less in urban counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.

9.2.C. Services

Component services include:

- Assessments and identifying current strengths and needs of the child and family (rendered by the treatment team)
- De-escalation of the crisis
- Family-driven and youth-guided planning
- Crisis and safety plan development
- Brief intensive individual counseling/psychotherapy
- Brief family therapy
- Skill building
- Psychoeducation
- Referrals and connections to additional community resources
- Collaboration and problem solving with other child- or youth-serving systems, as applicable
- Psychiatric consult, as needed

9.2.D. Qualified Staff

Intensive crisis stabilization services must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional [QIDP], if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision. Paraprofessionals must have at least one year of satisfactory work experience providing services to children with serious emotional disturbance and/or intellectual/developmental disabilities, as applicable. Team

members must have access to an on-call psychiatrist by telephone, as needed. At minimum, all team members must be trained in crisis intervention and de-escalation techniques.

9.2.E. Location of Services

Intensive crisis stabilization services are to be provided in the home or community at the preference of the parent or caregiver to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or detention centers; or
- Residential settings (e.g., Child Caring Institutions, Crisis Residential).

9.2.F. Individual Plan of Service

Intensive crisis stabilization services may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed. Children who are receiving home based services can also receive this mobile service. If it is clinically appropriate, the home based therapist is able to respond in person to the one hour urban and two hour rural time frame in lieu of the mobile team.

If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant ongoing treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs.

If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan.

Planned mobile intensive crisis stabilization services for children can occur as part of a crisis plan or proactive response to support the child and family. The goal would be to stabilize and connect to ongoing services. In these planned situations, the response time is not required.

SECTION 10 – OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

The PIHP is responsible for authorizing and paying for Medicaid admissions and continued stays in partial hospitalization programs by Medicaid beneficiaries.

- Admissions - beneficiaries may be referred to a partial hospitalization program from psychiatric inpatient hospitals or psychiatric units, referring providers, or PIHPs, or they may present themselves at the outpatient hospital without a referral.
- Continued stays must be authorized by the PIHP.

Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services. The outpatient partial hospitalization program must bill the PIHP for authorized services according to procedures and rates established between the facility and the PIHP.

10.1 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: ADULT

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms ➢ Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation are not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others. ▪ Disruptions of Self-Care and Independent Functioning ➢ The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder. ➢ Beneficiary is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program. ➢ The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.). ➢ There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations. ▪ Danger to Self ➢ There is modest danger to self, reflected in: intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities. ➢ The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk. ▪ Danger to Others ➢ Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions. ➢ There has been minor destructive behavior toward property without endangerment of others.

	▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs, and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.2 Partial Hospitalization Admission Criteria: Children and Adolescents

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).

Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least **two** of the following manifestations are present: ▪ Psychiatric Signs and Symptoms ➢ Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others. ▪ Disruptions of Self-Care and Independent Functioning ➢ The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness. ➢ The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program. ➢ There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.). ➢ There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness. ▪ Danger to Self ➢ There is modest danger to self, reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential, intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, passive death wishes, or slightly self-endangering activities. ➢ The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.

	▪ Danger to Others ➢ Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions. ➢ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least **one** of the following: ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.3 Partial Hospitalization Continuing Stay Criteria for Adults, Adolescents and Children

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations or medication complications, similar to those which justified the beneficiary's admission

certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes), which remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	▪ Persistence of symptoms, impairments, harm inclinations or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria. ▪ Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.
Intensity of Service	▪ The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or medication complications that necessitated admission to the program. ▪ The beneficiary is making progress toward treatment goals or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks themself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 Documentation

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

SECTION 12 – SUBSTANCE ABUSE SERVICES

12.1 OUTPATIENT CARE

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services.

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination.

Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Criteria. For those in long term or continuous treatment, assessment should occur on an annual basis to ensure medical necessity and to update the beneficiary's treatment/recovery plan. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.

12.1.A. ELIGIBILITY

Outpatient care may be provided only when:

- The service meets medical necessity criteria.
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes.
- The service is based on individualized determination of need.
- The service is cost effective.
- The American Society of Addiction Medicine (ASAM) Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Criteria:
  - Withdrawal potential
  - Medical conditions and complications
  - Emotional, behavioral or cognitive conditions and complications
  - Readiness to change
  - Relapse, continued use or continued problem potential
  - Recovery/living environment.

This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:

- an acceptable readiness to change level;
- minimal or manageable medical conditions;
- minimal or manageable withdrawal risks;
- emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- minimal or manageable relapse potential; and
- a minimally to fully supportive recovery environment.

12.1.B. Covered Services

Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

Individual Assessment	A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.
Individual Treatment Planning	The beneficiary must be directly involved with developing the plan that must include Recovery Support Preparation/Relapse Prevention Activities.
Individual Therapy	Face-to-face counseling services with the beneficiary.
Group Therapy	Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities.
Family Therapy	Face-to-face counseling with the beneficiary and the significant other and/or traditional or non-traditional family members.
Crisis Intervention	A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.
Referral/Linking/ Coordinating/ Management of Services	For the purpose of ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary (frequently referred to as substance use disorder case management).
Peer Recovery and Recovery Support	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.
Compliance Monitoring	For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing).

Early Intervention	Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.
Detoxification/ Withdrawal Monitoring	For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.
Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/ CSAT) Approved Pharmacological Supports	Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection.
Substance Abuse Treatment Services	Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, recovery support services, and treatment based on medical necessity. They may include individual, group and family treatment. These services are provided under the supervision of a SATS or SATP.

12.1.C. Admission Criteria

Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently.

Reauthorization of services can be denied in situations where the beneficiary has:

- not been actively involved in their treatment, as evidenced by repeatedly missing appointments;
- not been participating/refusing to participate in treatment activities;
- continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services.

Beneficiaries may also be terminated from treatment services based on these violations.

12.1.D. Service Intensity

The medically necessary outpatient services correspond to the frequency and duration of services established by the ASAM levels of care and are referred to as follows:

- Level 0.5 – Early Intervention
- Level 1.0 – Outpatient
- Level 2.1 – Intensive Outpatient

- Level 2.5 – Expanded Intensive Outpatient

Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/ duration of services may be utilized if these are medically necessary. The ASAM levels correspond with established hours of services that take place during a week.

ASAM Level 0.5	Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present.
ASAM Level 1.0	Services from one hour to eight hours during a week.
ASAM Level 2.1	Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment.
ASAM Level 2.5	Services that are offered 20 or more hours in a week.

12.2 Medication Assisted Treatment (MAT) [Change Made 4/1/2025]

Medication-Assisted Treatment (MAT) is the use of medications often used in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders (SUDs). Medications used in MAT are approved by the Food and Drug Administration (FDA). MAT programs are clinically driven and tailored to meet each patient's needs.

MAT is a covered service for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service. The State assures coverage of Naltrexone, Buprenorphine, and Methadone and all the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262). The State also provides coverage for additional MAT drugs per the Michigan Preferred Drug List (PDL) used by the Fee for Service (FFS) pharmacy program. This is described as the Single PDL. (Refer to the Directory Appendix for Michigan Preferred Drug List website information.)

The State assures that Medications for Opioid Use Disorder (MOUD) for MAT is provided by Opioid Treatment Programs (OTPs) that meet the requirements in 42 CFR Part 8. **(revised 4/1/2025)**

Beneficiaries must have a completed bio-psycho-social assessment using a state approved tool at the time of admission, and annually thereafter if in continuous treatment.

12.2.A. MAT MOUD Within OTPs [Title Revised 4/1/2025]

12.2.A.1. Provision of Services [Changes Made 4/1/2025]

Opioid-dependent beneficiaries may be provided chemotherapy using MOUD as a treatment service. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.

- The physician must be licensed to prescribe controlled substances, as well as licensed to work at an OTP.
- The MOUD component of the substance use disorder treatment program must be:
  - licensed as such by the state;
  - certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT);
  - licensed by the Drug Enforcement Administration (DEA); and
  - accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission [TJC] and the Commission on Accreditation of Rehabilitation Facilities [CARF]).
- MOUD must be administered by an appropriately licensed MD/DO, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed practical nurse, or pharmacist. **(revisions made 4/1/2025)**

12.2.A.2. COVERED SERVICES [CHANGE MADE 4/1/2025]

Covered services for Methadone and pharmacological supports and laboratory services, as required by DPT/CSAT regulations and the Administrative Rules for Substance Use Disorder Service Programs in Michigan, include:

- Medications for Opioid Use Disorder (MOUD) **(revised 4/1/2025)**
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests (including health screening tests as part of the initial physical exam, pregnancy test at admission, and required toxicology tests)
- TB skin test (as ordered by physician)

12.2.A.3. ELIGIBILITY CRITERIA [CHANGES MADE 4/1/2025]

Medical necessity requirements shall be used to determine the need for MOUD as a treatment and recovery service.

All dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed: **(revisions made 4/1/2025)**

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications
- Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
- Treatment acceptance/resistance

- Relapse/continued use potential
- Recovery/living environment

12.2.A.4. CONTINUUM OF CARE [CHANGES MADE 4/1/2025]

Decisions to admit an individual for MOUD maintenance must be based on medical necessity criteria, satisfy the LOC determination using the dimensions of the ASAM Criteria, the person meets diagnostic criteria for a moderate to severe opioid use disorder (OUD); the individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose.

Admission procedures require a screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with MOUD. A full physical examination must be completed within 14 calendar days following an individual's admission to the OTP. The physician may refer the individual for further medical assessment as indicated.

Consistent with the LOC determination, individuals requesting MOUD must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification
- Sub-acute Detoxification
- Residential Care
- Buprenorphine/Naloxone
- Non-Medication Assisted Outpatient Treatment

Special Circumstances for Admissions

There are special circumstances for the admission of pregnant women, pregnant adolescents, and adolescents.

Pregnant Women	▪ Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. ▪ Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an Opioid Treatment Program (OTP) provided the pregnancy is certified by the OTP physician and treatment is found to be justified. ▪ For pregnant individuals, evidence of current physiological dependence is not necessary. ▪ Pregnant opioid-dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary. ▪ OTPs must obtain informed consent from pregnant women, and all women admitted to MOUD treatment who may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. ▪ Because MOUD and opioid withdrawal are not recommended during pregnancy due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.
(category deleted 4/1/2025)	
Adolescents (title revised 4/1/2025)	▪ **(bullet point removed 4/1/2025)** ▪ No individual under 14 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult (designated by the relevant state authority) consents, in writing, to such treatment. **(text deleted 4/1/2025)**

Medical Maintenance Phase

When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (medication only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered when making the decision to move to medical maintenance:

- **(bullet point deleted 4/1/2025)**
- Absence of active substance use disorders for the period indicated by federal and state regulations. **(revised 4/1/2025)**
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.

- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.
- Adequate social support system and absence of significant non-stabilized co-occurring disorders.

Discontinuation/Termination Criteria

Discontinuation/termination from MOUD treatment refers to the following situations:

- Beneficiaries must discontinue treatment with MOUD when treatment is completed with respect to both the medical necessity for the medication and for counseling services.
- Beneficiaries may be terminated from services if there is clinical and/or behavioral non-compliance.
- If a beneficiary is terminated:
  - The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
  - The OTP must make an effort to ensure that the beneficiary follows through with the referral.
  - These efforts must be documented in the medical record.
  - The OTP must follow the procedures of the funding authority in coordinating these referrals.
- Any action to terminate treatment of a Medicaid beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.

Services are discontinued/terminated, either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

Completion of Treatment

The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs MOUD as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

Administrative Discontinuation

Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The OTP must work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.

Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:

- **(bullet point deleted 4/1/2025)**
- Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.)

  OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates. **(revised 4/1/2025)**

  OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.
- Repeated failure to submit to toxicology sampling as requested.
- **(bullet point deleted 4/1/2025)**
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of MOUD and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)

The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:

- Possession of a weapon on OTP property
- Assaultive behavior against staff and/or other individuals
- Threats (verbal or physical) against staff and/or other individuals
- Diversion of controlled substances, including MOUD
- Diversion and/or adulteration of toxicology samples
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic

- Sexual harassment of staff and/or other individuals
- Loitering on the clinic property or within a one-block radius of the clinic

Administrative discontinuation of services can be carried out by two methods:

- **Immediate Termination -** This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.
- **Enhanced Tapering Discontinuation -** This involves an accelerated decrease of the MOUD dose (usually by 10 mg or 10 percent a day). The manner in which MOUD is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the beneficiary's chart.

12.3 Primary Care Office-Based Substance Use Treatment (OBSUT)

Primary care providers who do not have a specialty substance use disorder (SUD) benefit services contract with the PIHP are permitted to seek fee for service (FFS) or Medicaid Health Plan reimbursement for substance use treatment services in an office-based setting. (Refer to the Primary Care Office-Based Substance Use Treatment (OBSUT) subsection in the Practitioner chapter for additional information regarding reimbursement provision.)

12.4 Sub-Acute Detoxification

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need.

The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Criteria.

- Outpatient Setting
  - Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level 1-WM, or ambulatory detoxification with extended on-site monitoring (ASAM Level 2-WM).
  - Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level 2-WM ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.
- Residential Setting
  - Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level 3.2-WM). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
  - Medically Monitored Inpatient Detoxification - Freestanding Detoxification Center – permanent facility with inpatient beds: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM Level 3.7-WM).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- Admission to sub-acute detoxification must be made based on:
  - Medical necessity criteria.
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria.
- Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

12.5 Residential Treatment

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a Substance Abuse Treatment Specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.

Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.
- Admissions to Residential Treatment must be based on:
  - Medical necessity criteria
  - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria
- Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

12.6 Excluded Services

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

Some Medicaid-covered services are available to substance abuse beneficiaries but are provided outside of the PIHP. PIHPs are not responsible to pay for the following:

- Acute detoxification;
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone);
- Medications used in the treatment/management of addictive disorders;
- Emergency medical care;
- Emergency transportation;

- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care; and
- Routine transportation to substance abuse treatment services which is the responsibility of the local MDHHS office or beneficiary's MHP.

SECTION 13 – TARGETED CASE MANAGEMENT/SUPPORT AND SERVICE COORDINATION

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Targeted Case Management	Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. For children and youth, a family driven, youth guided planning process should be utilized. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes. Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.
Supports Coordinator/Supports Coordinator Assistant/Services and Supports Broker	Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following: ▪ Planning and/or facilitating planning using person-centered principles. ▪ Developing an individual plan of service using the person-centered planning process. ▪ Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports. ▪ Brokering of providers of services/supports. ▪ Assistance with access to entitlements and/or legal representation. ▪ Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers. The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is used, a qualified supports coordinator or targeted case manager must supervise the assistant.

	A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed. Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place. If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's individual plan of service. Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure their ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

13.1 Provider Qualifications

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 Determination of Need

The determination of the need for case management/supports coordination must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management/supports coordination is needed or not must be documented in the beneficiary's record.

Beneficiaries must be provided choice of available, qualified case management/supports coordination staff upon initial assignment and on an ongoing basis.

13.3 Core Requirements

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Independent facilitation of the person-centered plan is made available. Individuals who receive specialty behavioral health supports and services have the right to choose an IF to facilitate the PCP process that is used to develop the IPOS.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions related to the beneficiary's plans, goals, and status.
- Identifying and addressing gaps in service provision and addressing all issues, i.e., housing and employment.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to ensure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.
- Assisting the beneficiary in developing social networks.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.

Documentation	The beneficiary's record must contain sufficient information to document the provision of case management/supports coordination, including the nature of the service, the date, and the location of contacts between the case manager/supports coordinator and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager/supports coordinator must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or their guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager/supports coordinator must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management/supports coordination monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management/supports coordination shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers/supports coordinators are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management/supports coordination shall not duplicate services that are the responsibility of another program.

13.4 Staff Qualifications

A primary case manager must be a qualified mental health or intellectual disability professional (QMHP or QIDP) or, if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QIDP.

Qualifications of supports coordinators are a minimum of a Bachelor's degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor's degree in a human services field and one year of experience with people with mental illness if supporting that population. Qualifications of supports coordinator assistants and independent services and supports brokers are a minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

SECTION 14 – CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)

The Children's Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.

Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master's social worker with consultation by a building specialist and an occupational therapist.

14.1 KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDHHS to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child's waiver services. The case manager, the child and their family, friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children's waiver service per month in order to retain eligibility.

14.2 ELIGIBILITY

The following eligibility requirements must be met:

- The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.
- The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.
- The child must reside with their birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.
- The child is at risk of being placed into an ICF/IID facility because of the intensity of the child's care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.
- The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).

- The child's intellectual or functional limitations indicate that they would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

14.3 Covered Waiver Services

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

14.3.A. Community Living Supports

Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.

Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.

The CMHSP must maintain the following documentation:

- A log of the CLS must be maintained in the child's record, documenting the provision of activities outlined in the plan.
- Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family.

All service costs must be maintained in the child's file for audit purposes.

14.3.B. Enhanced Transportation

Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services,

activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record.

Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.

14.3.C. Environmental Accessibility Adaptations (EAAs)

Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable them to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.

Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes.

The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child's records. The CWP is a funding source of last resort.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the

requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child's home.

All work must be completed while the child is enrolled in the CWP.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDHHS are not obligated for any restoration costs.

If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.

Additional square footage may be prior authorized following a MDHHS specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.

14.3.D. Family Training

This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home.

Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.

14.3.E. Non-Family Training

This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QIDP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social

interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.

14.3.F. Fencing

Fencing may be approved with documentation that it is essential to achieve the outcomes specified in the child's individual plan of services and necessary to meet a child's health and safety needs. Authorization for fencing is for a maximum of 200 feet of standard chain link fence and one gate. If it is determined that chain link fencing will not meet the child's health and safety needs, a standard stockade fence may be considered.

14.3.G. Financial Management Services/Fiscal Intermediary Services

Healthcare Common Procedure Coding System (HCPCS) code "T2025" should be used to bill for this service. This is a "per month" service with a maximum unit of one per month.

Financial Management Services/Fiscal Intermediary Services include, but are not limited to:

- Facilitation of the employment of service workers by the child's parent or guardian acting as the consumer's representative, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the consumer – through their parent or guardian - to self-direct needed services. These functions may include helping the consumer's representative recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing); contracting with or employing providers of services; verification of provider qualifications (including reference and background checks); and assisting the consumer and their representative to understand billing and documentation requirements.

This is a service that handles the financial flow-through of Medicaid dollars for children enrolled in the CWP who are using Choice Voucher arrangements. This CWP waiver service is available only to CWP consumers whose parent or guardian, serving as the consumer's representative, chooses to self-direct selected services through Choice Voucher arrangements. A CMHSP may terminate self-direction of services (and therefore Financial Management Services) when the health and welfare of the consumer is in jeopardy due to the failure of the consumer's representative to direct services and supports or when the consumer's representative consistently fails to comply with contractual requirements.

A fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for

the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary receives funds from the CMHSP and makes payments authorized by the consumer's parent or guardian, as the consumer's representative. The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers.

The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, attorney). The fiscal intermediary must meet requirements as identified in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract – Attachment C3.4.4 Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY12 (and subsequent years) – Attachment P3 4.4.

14.3.H. Overnight Health and Safety Supports

NOTE: OHSS is not available for individuals residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian.

The need for OHSS must be reviewed and established through the person-centered planning process with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety.

14.3.H.1. Coverage [Changes Made 4/1/2025]

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period.

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the Individual Plan of Service (IPOS), encompassing both health and safety support services needed for the individual to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.
- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow an individual to remain at home safely after all other available

preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.

- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night.
- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).
- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.
- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.
- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.
- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.
- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
- OHSS is not available for an individual who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.
- OHSS is not intended to supplant services, such as respite, for the relief of the primary caregiver or legal guardian living in the same home. **(revised 4/1/2025)**
- OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. **(text added 4/1/2025)**
- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.

14.3.H.2. Coordination of Services and Care

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into this category of "round-the-clock" by the nature and institutional level of care required for HCBS Waiver participants. OHSS is intended to supplement other HCBS (i.e., Community Living Supports [CLS], respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the other community support services to prevent issues of duplicative services. OHSS is complementary of the other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of an individual overnight.

14.3.H.3. Provider Services

Providers have the responsibility for the health, welfare, and safety of the beneficiary overnight and must be awake to have the ability to intervene on behalf of the beneficiary. This assistance may take the form of observation and minor redirection of the beneficiary to perform tasks that will enable the beneficiary to maintain their overnight health and sleep safety.

Providers may perform minor redirection and/or prompting that are incidental to the care and supervision of the beneficiary over the course of the night such as:

- The ability to intervene on behalf of the beneficiary supervision of overnight activities, such as reinforcing independent living skills and minor redirection of their independent daily living tasks.
- Provide the level of supervision needed to ensure a beneficiary's safety, along with the actions required if a beneficiary's health or welfare are at risk.
- Safeguard the individualized supports needed overnight appropriate to the beneficiary's needs. Common issues, which include fire and evacuation ability, ability to respond independently to health needs during the night, and safety awareness.

14.3.I. Respite Care

Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All

respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year.

The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.

14.3.J. Specialized Medical Equipment and Supplies

Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase their ability to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies.)

Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.

A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.

The following are examples of items not covered under this service:

- Items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal.
- Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home.
- Items that would normally be available to any child and would ordinarily be provided by the family.
- Items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs).
- The purchase or lease of vehicles and any repairs or routine maintenance to the vehicle.
- Educational supplies and equipment expected to be provided by the school.

Local Authorization of Specialized Medical Equipment and Supplies	As defined below under the various Healthcare Common Procedure Coding System (HCPCS) codes, the CMHSP may locally authorize selected medical equipment and supplies covered under this service category. Medicaid payment will not be made for items that exceed quantity/frequency limits or established Medicaid fee screens as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the equipment or supply is authorized. ▪ **Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks" (HCPCS T1999)** This code is used to bill Medicaid for age-appropriate adaptive toys identified in the child's individual plan of services to address the adaptive or therapeutic need for the item and the specific habilitative outcome. Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games, educational or non-adaptive toys/software, CD/DVD players, camera, film, computers) are not covered. ▪ **Personal care item, not otherwise specified, each; identify product in "Remarks" (HCPCS S5199)** This code is used to bill Medicaid for ADL aids that enable the child to be as independent as possible in areas of self-care. The child's individual plan of services must describe the purpose and use of the ADL aid and any training that the child requires for its use. ADL aids must not be similar in function to items previously billed to Medicaid. ▪ **Specialized supply, not otherwise specified, waiver; identify product in "Remarks" (HCPCS T2028)** This code is used to bill Medicaid for allergy control supplies used for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the child's individual plan of services. Household items routinely found in a home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).

State-Level Prior Authorization of Specialized Medical Equipment and Supplies	All other items and services covered under this category must be prior authorized by the MDHHS CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. (Refer to the Children's Waiver Program [CWP] Prior Authorization subsection for details regarding the prior authorization process.) Prior authorization will not be given for items and services that exceed quantity/frequency limits as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the service is authorized. Pursuant to prior authorization by the MDHHS CWP Clinical Review Team and provision of the items or service, Medicaid payment will be at the rate prior authorized. ▪ **Specialized medical equipment, not otherwise specified, waiver (HCPCS T2029)** This code is used to bill Medicaid for environmental safety and control devices that enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The child's individual plan of services must address the use of the device and include any training that the child requires for its use. Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems, and storage cabinets. This service is limited to five environmental safety and control devices or sets of devices per quarter. A set is considered a group of like items that must be purchased in a quantity to meet the child's needs, e.g., outlet plug covers. ▪ **Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (HCPCS K0739)** This code is used to bill Medicaid for repairs to specialized medical equipment that are not covered benefits through other insurances. There must be documentation in the child's individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP must provide evidence of training in the use of the equipment to prevent future incidents. ▪ **Vehicle modifications, waiver; per service (HCPCS T2039)** This code is used to bill Medicaid for modifications to full-size vans, van lifts and wheelchair tie-down systems. Modifications to the family-owned van must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The individual plan of services must specify the child's accessibility needs that will be addressed by these modifications.

Prior authorization for a van lift will be considered no more frequently than once every five years, which is the minimum life expectancy of a lift.

When purchasing new vehicles, many automobile manufacturers offer a rebate of up to $1,000 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP must request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.

Other modifications to a full-size van, such as raised doors, which are necessary to meet the child's accessibility needs will be considered. It is expected that the CMHSP will use prudence in considering and processing beneficiary requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a full-size van; purchasing a vehicle that has a raised roof). Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift. Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. The purchase of a vehicle or maintenance to the vehicle is the family's responsibility.

If the vehicle is stolen or damaged beyond repair within five years of the purchase, replacement would only be considered with documentation that the existing lift cannot be transferred to a new van and that no other funding source (e.g., automobile insurance, homeowner's insurance, personal liability, judgment settlement, etc.) is available to cover the replacement.

- **Durable medical equipment, miscellaneous (HCPCS E1399)**

  This code is used to bill Medicaid for durable medical equipment as described below:

  - Window air-conditioning unit for the room where the child spends the majority of their time (e.g., sleeping area). The child must have a documented medical diagnosis of one of the following specific medical diagnoses or conditions:
    - temperature regulation dysfunction due to brain injury or other medical diagnosis;
    - severe respiratory distress secondary to asthma, permanent lung damage, or other medical conditions which are exacerbated by heat and humidity;
    - severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus) which may result in hospitalization; or
    - severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled.

	➢ Generator for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration. The local power company must be notified in writing of the need to restore power on a priority basis due to the child's needs. ➢ Therapeutic items, assistive technology, and other durable medical equipment for a child who has sensory, communication, or mobility needs when the item is reasonably expected to enable the child to perceive, control or communicate with the environment in which the child lives, to have a greater degree of independence than would be possible without the item or device, or to benefit maximally from a program designed to meet physical or behavioral needs.

14.3.K. Specialty Services

Specialty Services include:

- Music Therapies;
- Recreation Therapies;
- Art Therapies; and
- Massage Therapies.

Specialty Services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid.

Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month.

The CMHSP must maintain a record of all Specialty Service costs for audit purposes.

Hourly care services are not covered under Specialty Services.

14.4 Children's Waiver Program (CWP) Prior Authorization

To determine if a specific service requires MDHHS CWP prior authorization, refer to the Covered Waiver Services subsection above. The CMHSP must complete and submit to the MDHHS CWP an original Prior Review and Approval Request (PRAR) form and the following documentation for each prior authorization request:

- Original current (within 365 days) prescription signed by a physician.
- Narrative justification of need completed by an appropriate professional.

- Documentation that the requested item, device, or modification is essential to the implementation of the child's individual plan of services and is of direct medical or remedial benefit to the child.
- A copy of the habilitation program (i.e., goals, objectives and methodologies) as related to the request and identified in the individual plan of services.
- Written denial of funding from other sources, including private insurance, Medicaid or CSHCS when applicable, charitable or community organizations, and housing grant programs. If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the PRAR to the MDHHS CWP.
- Three similar bids for requests costing equal to or more than $1,000; only one bid is required for requests costing less than $1,000. If fewer than three bids are obtained for requests costing equal to or more than $1,000, documentation must describe what efforts were made to secure the bids, and why fewer than three bids were obtained.

The completed PRAR and supporting documentation must be submitted to the MDHHS Children's Waiver Program. (Refer to the Directory Appendix for contact information.)

14.5 Provider Qualifications

14.5.A. Individuals Who Provide Respite and CLS

Individuals who provide respite and CLS must:

- Be at least 18 years of age.
- Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Be able to perform basic first aid and emergency procedures.
- Be trained in recipient rights.
- Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-provider contracting.

14.5.B. Individuals Performing Case Management Functions

Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) and have:

- A minimum of a Bachelor's degree in a human services field.
- One year of experience working with people with developmental disabilities.

SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid State Plan covered services. A HSW beneficiary must receive at least one HSW habilitative service per month to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in their individual plan of services (IPOS) developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The PIHP's enrollment process responsibilities also include confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. MDHHS continues to review bed size as part of the waiver enrollment which includes a limit of no more than 12 beds. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, does not receive at least one HSW habilitative service per month, moves out of the state, withdraws from the program voluntarily, or dies. An OBRA assessment must be provided for disenrollment due to nursing facility placement. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Specialty Behavioral Health Services. (Refer to the Directory Appendix for contact information.)

PIHPs must report inactive status on HSW beneficiaries not living in community settings (e.g., hospital, nursing facility, Child Caring Institution [CCI], jail, prison, or juvenile detention facility). HSW beneficiaries can be on inactive status for 90 days. After the 90-day period, the PIHP shall start the disenrollment process if there is no transition planning for returning to the community.

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.

15.1 Waiver Supports and Services

15.1.A. Community Living Supports (CLS)

NOTE: This is a habilitative service.

Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or Medicaid State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite). The supports are:

- Assisting (that exceeds the Medicaid State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with:
  - Meal preparation;
  - Laundry;
  - Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);
  - Activities of daily living, such as bathing, eating, dressing, personal hygiene; and
  - Shopping for food and other necessities of daily living.
- Assisting, supporting and/or training the beneficiary with:
  - Money management;
  - Non-medical care (not requiring nurse or physician intervention);
  - Socialization and relationship building;
  - Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through Medicaid Fee for Service [FFS] or the Medicaid Health Plan [MHP]) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);
  - Leisure choice and participation in regular community activities;
  - Attendance at medical appointments; and
  - Acquiring goods and/or services other than those listed under shopping and non-medical services.
- Reminding, observing, and/or monitoring of medication administration.

CLS does not include costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.

For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, Medicaid State Plan coverage of Personal Care in Specialized Residential Settings.

If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect their needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to ADL, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

15.1.B. Enhanced Medical Equipment and Supplies

Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the IPOS and must enable the beneficiary to increase their abilities to perform ADL; or to perceive, control, or communicate with the environment.

Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage.

- "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the IPOS.
- "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal.

The IPOS must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a physician's prescription as defined in the General Information section of this chapter. An order is valid one year from the date it was signed. This coverage includes:

- Adaptations to vehicles;
- Items necessary for life support;
- Ancillary supplies and equipment necessary for proper functioning of such items; and
- Durable and non-durable medical equipment not available under the Medicaid State Plan.

Generators may be covered for a beneficiary who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.

Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.

Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home are not included.

Items that are considered family recreational choices are not covered (e.g., outdoor play equipment, swimming pools, pool decks and hot tubs). The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies expected to be provided by the school are not covered. Eyeglasses, hearing aids, and dentures are not covered.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.

Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the IPOS that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before payment is made for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment

requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.

15.1.C. Enhanced Pharmacy

Enhanced Pharmacy is defined as physician-ordered, nonprescription "medicine chest" items as specified in the beneficiary's IPOS. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Only the following items are allowable:

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies;
- Vitamins and minerals;
- Special dietary juices and foods that augment, but do not replace, a regular diet;
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
  - A history of aspiration pneumonia, or
  - Documentation that the beneficiary is at risk of insertion of a feeding tube without thickening agents for safe swallowing;
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads);
- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes); and
- Special items (i.e., accommodating common disabilities -- longer, wider handles -- e.g., tweezers and nail clippers).

Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions.

HSW funds cannot be used to pay for copays for other prescription plans the beneficiary may have.

The services under Enhanced Pharmacy are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT.

15.1.D. Environmental Modifications

Environmental Modifications are physical adaptations to the home and/or workplace required by the beneficiary's assessed need and identified in the IPOS that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable them to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.

Adaptations may include:

- The installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and
- Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers.

Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.

"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the IPOS. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. All items must be ordered on a physician's prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the IPOS as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the

requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home.

The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract or bid proposal. If the contract is terminated prior to the completion of the work, HSW funds may not be used to pay for any additional costs resulting from the termination of the contract.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the beneficiary moves. If a beneficiary or their family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to ensure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to address the IPOS (e.g., roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need.

Environmental modifications for **licensed settings** includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.

The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes.

The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The beneficiary, with the direct assistance by the PIHP supports coordinator, when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants, for assistance. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort.

Adaptations to the **work environment** are limited to those necessary to accommodate the beneficiary's individualized needs and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), or covered by the Michigan Department of Labor and Economic Opportunity (LEO) Michigan Rehabilitation Services (MRS) or the LEO Bureau of Services for Blind Persons (BSBP).

All services must be provided in accordance with applicable state or local building codes.

15.1.E. Family Training

Family Training includes training and counseling services for the families of beneficiaries served by the waiver. For purposes of this service, "family" is defined as family members who live with or provide care to the beneficiary on the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws.

Training includes instructions about treatment regimens and use of equipment specified in the IPOS, and includes updates as needed to safely maintain the beneficiary at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's IPOS.

Not included are individuals who are employed to provide waiver services for the beneficiary.

The services under Family Training are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT.

15.1.F. Fiscal Intermediary

Fiscal Intermediary services are defined as services that assist the beneficiary, or a representative identified in the beneficiary's IPOS, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling their individual budget, and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring beneficiary-directed budget expenditures and identifying potential over- and under-expenditures;
- Ensuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification

of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services are available only to beneficiaries choosing the self-determination option.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's IPOS so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

15.1.G. Goods and Services

The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the beneficiary using self-directed services and facilitate creative use of funds to accomplish the goals identified in the IPOS through achieving better value or an improved outcome. Goods and Services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and CLS and other one-to-one support as described in the HSW or covered Medicaid State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.

A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.

Goods and Services are available only to beneficiaries who self direct their services whose individual budget is lodged with a fiscal intermediary.

This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.

15.1.H. Non-Family Training

This service provides coaching, training, supervision, and monitoring of CLS and respite staff by clinical professionals working within the scope of their practice. Professional staff work with CLS and respite staff to implement the beneficiary's IPOS, with focus on all behavioral health services designed to assist the beneficiary in acquiring, retaining, and improving self- help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. The activities of the professional staff ensure the appropriateness of services delivered by CLS and respite staff and continuity of care. The service provider is selected on the basis of their competency in the aspect of the IPOS on which training is conducted.

Services under Non-Family Training are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT.

15.1.I. Out-of-Home Nonvocational Habilitation

NOTE: This is a habilitative service.

This service provides assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides.

Examples of incidental support include:

- Aides helping the beneficiary with their mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.
- When necessary, helping the person to engage in the habilitation activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's IPOS.

These supports focus on enabling the beneficiary to attain or maintain their maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the IPOS. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

15.1.J. Overnight Health and Safety Supports (OHSS) [Changes Made 4/1/2025]

NOTE: Overnight Health and Safety Supports (OHSS) is not available for beneficiaries residing in licensed non-community facilities or settings.

Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian.

The need for OHSS must be reviewed and established through the person-centered planning process, with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety.

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period.

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the IPOS, encompassing both health and safety support services needed for the beneficiary to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.
- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow a beneficiary to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.
- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night.
- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).
- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.
- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.
- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.
- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.
- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
- OHSS is not available for a beneficiary who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.

- OHSS is not intended to supplant services, such as respite, for the relief of the primary caregiver or legal guardian living in the same home. **(revised 4/1/2025)**
- OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. **(text added 4/1/2025)**
- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.

15.1.J.1. Coordination of Services and Care

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into a category of "round-the-clock" by the nature and institutional level of care required for Home and Community Based Services (HCBS) Waiver beneficiaries. OHSS is intended to supplement other HCBS (i.e., CLS, respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the other community support services to prevent issues of duplicative services. OHSS is complementary of other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of a beneficiary overnight.

15.1.J.2. Provider Services

Providers have the responsibility for the health, welfare, and safety of the beneficiary overnight and must be awake to have the ability to intervene on behalf of the beneficiary. This assistance may take the form of observation and minor redirection of the beneficiary to perform tasks that will enable the beneficiary to maintain their overnight health and sleep safety.

Providers may perform minor redirection and/or prompting that are incidental to the care and supervision of the beneficiary over the course of the night such as:

- The ability to intervene on behalf of the beneficiary supervision of overnight activities, such as reinforcing independent living skills and minor redirection of their independent daily living tasks.
- Provide the level of supervision needed to ensure a beneficiary's safety, along with the actions required if a beneficiary's health or welfare is at risk.
- Safeguard the individualized supports needed overnight appropriate to the beneficiary's needs. Common issues include fire and evacuation ability, ability to respond independently to health needs during the night, and safety awareness.

15.1.K. Personal Emergency Response Systems (PERS)

PERS can be identified as electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once the button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to 12 monthly monitoring services per year.

PERS coverage should be limited to beneficiaries living alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.

15.1.L. Prevocational Services

NOTE: This is a habilitative service.

Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to individual CIE. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and their care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability. Individual competitive integrated employment (CIE) or supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for individual CIE or receiving supported employment services.

Prevocational services should enable each beneficiary to attain individual CIE in the community in which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to:

- ability to communicate effectively with supervisors, co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to tasks;
- workplace problem solving skills and strategies;
- general workplace safety; and
- mobility training.

Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting their outcomes. Prevocational services provide learning and work experiences, including volunteering, where the beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in CIE.

Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or CLS, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations.

Beneficiaries participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to permanent integrated employment.

Prevocational services needed for each beneficiary are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of IDEA (20 U.S.C. 1401(16 and 17)).

Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to ensure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.

Assistance with personal care or other ADL that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate Medicaid State Plan Home Help service or CLS service under the waiver, but the same activity cannot be reported as being provided to more than one service.

Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services.

15.1.M. Private Duty Nursing (PDN)

Private Duty Nursing (PDN) services are skilled nursing interventions provided to beneficiaries age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to their developmental disability. PDN

includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's IPOS. PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through Medicaid State Plan services, e.g., Home Health. The beneficiary receiving PDN must also require at least one of the following habilitative services:

- CLS
- Out-of-home non-vocational habilitation
- Prevocational or supported employment

To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.

Medical Criteria I – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition (TPN) delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of

medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.

- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for PDN. A determination of need for continued PDN services is based on the continuous skilled nursing care.

- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in three or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every three hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
  - performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
  - managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;

- deep oral (past the tonsils) or tracheostomy suctioning;
- injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);
- nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
- TPN delivered via a central line and care of the central line;
- continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;
- monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.

The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the beneficiary's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN (e.g., diaper changes) but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a Medicaid State Plan service. (Refer to the Home Help chapter of this Manual for additional information.) If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to ensure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written IPOS.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required as defined in the General Information section of this chapter.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Civilian Health, and Medical Program of the Department of Veterans Affairs [CHAMPVA], Worker's Compensation, an indemnity policy, automobile insurance) for PDN and will assist the beneficiary in selecting a PDN provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the IEP identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process is available to ensure the beneficiary's health, safety and welfare if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the IPOS, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's IPOS and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to their condition.

Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:
  - A temporary increase in the intensity of required assessments, judgments, and interventions.
  - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

  The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care as the result of one of the following:
  - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
  - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
  - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

  "Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.

  "Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

  "Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or CLS staff.

  This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.

If a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and ensuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.

The services under PDN are limited to additional services not otherwise covered under the Medicaid State Plan, including EPSDT.

PDN is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility. Refer to the Private Duty Nursing chapter of the MDHHS Medicaid Provider Manual for additional information.

15.1.N. Respite Care

Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid Medicaid State Plan (e.g., home help) or waiver service (e.g., CLS) or service through other programs (e.g., school).

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work. The beneficiary's record must clearly differentiate respite hours from CLS services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.

Respite services may be provided in the following settings:

- Waiver beneficiary's home or place of residence.
- Licensed foster care home.
- Facility approved by the State that is not a private residence, such as:
  - Group home; or
  - Licensed respite care facility.
- Home of a friend or relative (not the parent of a minor beneficiary, the spouse of the beneficiary served, or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS.

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS-approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from CLS services.

15.1.O. SUPPORTED EMPLOYMENT

NOTE: This is a habilitative service.

Competitive integrated employment (CIE) is employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services seek to align with the Work Innovation and Opportunity Act (WIOA) to achieve desired outcomes for beneficiaries.

Supported employment services support CIE in the general workforce where the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment services can be provided through many different service models.

Specific supported employment services include the two following categories:

- Individual Employment Services:
  - Supported Individual Employment Services for Job Development/Career Planning support CIE that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Such services may provide ongoing supports to beneficiaries who, because of their disabilities, need some fading level of supports to be successful. Additionally, this service array may include intensive on-going support to obtain or maintain an individual job in competitive or customized employment, or self-employment in CIE in the general workforce for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after a reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry, or community-based settings. This service supports sustained paid employment at or above the minimum wage in CIE in the general workforce in a job that meets personal and career goals.
  - Individual supported employment services are individualized and may include any combination of the following services:
    - vocational/job-related discovery or assessment
    - person-centered employment planning
    - job placement/job development with prospective employers

- job analysis
- customized employment and job carving
- training and systematic instruction
- benefits management, financial literacy, asset development and career advancement services
- training and planning
- transportation
- other workplace support services, including services not specifically related to job skill training that enable the beneficiary to attain a job in a CIE setting of their choice.

- Group Employment Services for two to six individuals:
  - Supported Group Employment Services and training activities provided in regular business, industry, and community settings for groups of two (2) to six (6) workers with disabilities, paying at least minimum wage in an integrated setting. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Group Employment Services must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and individuals without disabilities in those workplaces. Funding for this service is to support sustained paid employment and work experience leading to further career development in individual CIE-based employment for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported Group Employment Services does not include volunteer work or vocational services provided in facility-based work settings.
  - Supported Group Employment Services may include any combination of the following services:
    - job analysis
    - training and systematic instruction
    - job coaching
    - benefits management support and financial literacy
    - training and planning
    - transportation
    - career advancement services
    - other workplace support services that may include services not specifically related to job skill training that enable the beneficiary to be successful in integrating into the workplace.

Federal Financial Participation (FFP) may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:

- Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
- Payments that are passed through to users of supported employment programs; or
- Payments for vocational training that is not directly related to a beneficiary supported employment program.

Supported employment service component(s) needed for each beneficiary are documented, coordinated, and nonduplicative of other services otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973, or under IDEA, MRS or BSBP. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change.

15.2 Supports and Services Provider Qualifications

Refer to the Behavioral Health Code Charts and Provider Qualifications document for Supports and Services Provider Qualifications. The document is available on the MDHHS website. (Refer to the Directory Appendix of this Manual for website information.)

SECTION 16 – MENTAL HEALTH AND SCHOOL SERVICES PROGRAM

This section is applicable to all PIHP programs/provider requirements and pertains to beneficiaries with mental illness and/or developmental disabilities.

The School-Services Program (SSP) policy requires cooperative agreements between the PIHP and the SSP provider. These agreements are not changed by the policies in this chapter. Any required releases of information are part of the existing requirements of the SSP provider.

The quality assurance standards for SSP also requires the coordination of care with other human service agencies where appropriate, including local public health departments, community mental health agencies and the beneficiary's physician or managed care providers. In addition, enrolled SSP providers are required to cooperate with other human service agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

When a beneficiary receives active treatment from a SBS provider, the services must be coordinated with the PIHP. If the PIHP provides mental health services for a special education student with serious emotional disturbance or a developmental disability, the PIHP must coordinate such services and information with special education and other human services agencies serving the student.

(Refer to the School Services Program Chapter of this manual for additional information.)

SECTION 17 –BEHAVIORAL HEALTH §1915(I) HOME AND COMMUNITY-BASED SERVICES (HCBS) STATE PLAN AMENDMENT

HCBS provides opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted population groups, such as people with intellectual or developmental disabilities, serious emotional disturbance and/or serious mental illnesses.

NOTE: Certain services found in this section are State Plan Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when delivered to children birth-21 years

Eligible beneficiaries may be enrolled in Michigan's BH 1915(i) SPA and receive the supports and services defined in this section, as well as other Medicaid covered State Plan services. A BH 1915(i) SPA beneficiary must receive at least one BH 1915(i) SPA service every three months, in addition to monthly monitoring to remain eligible.

17.1 ELIGIBILITY

The BH 1915(i) SPA benefit is available to individual beneficiaries with a serious emotional disturbance, serious mental illness and/or intellectual/developmental disability who are currently residing in a HCBS setting and meet the needs-based criteria defined below. Beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP on an annual basis.

17.1.A. NEEDS-BASED CRITERIA

- Have a substantial functional limitation in one or more of the following areas of major life activity:
  - Self-care
  - Communication
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency; and
- Without §1915(i) services, a beneficiary is at risk of not increasing or maintaining a sufficient level of functioning in order to achieve their individual goals of independence, recovery, productivity, and/or community inclusion and participation.

The PIHP provider network will perform the face-to-face assessments, compile required documentation, and submit findings to the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA). BPHASA will make the determination of needs-based criteria through an independent evaluation and re-evaluation. The PIHPs must have a network of qualified providers responsible for conducting the assessment, including specific training in an individual's needs for HCBS. These providers must meet one of the following qualifications: Mental Health Professional (MHP), Qualified

Intellectual Disability Professional (QIDP) or Qualified Mental Health Professional (QMHP). Refer to the Behavioral Health Code Charts and Provider Qualifications document for Supports and Services Provider Qualifications. The Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

17.1.B. Independent Evaluations and Re-evaluations

For an independent evaluation/re-evaluation, BPHASA staff will apply the needs-based criteria to determine whether the individual in the targeted group is eligible for §1915(i) benefit services. The PIHP network will utilize standardized instruments to assist in identifying level of need (i.e., Level of Care Utilization System [LOCUS], Supports Intensity Scale [SIS], American Society of Addiction Medicine [ASAM], Global Appraisal of Individual Needs Initial [GAIN-I]), administer other face-to-face assessments related to the individual's functional abilities (i.e., Essential for Living [EFL], Assessment of Functional Living Skills [AFLS], administer other adaptive behavior/global functioning scales, etc.), and identify services and supports required to reach the expected outcomes of community inclusion and participation. The PIHP network will provide evidence to BPHASA for making the needs-based eligibility determination through a Waiver Support Application (WSA) portal.

- For children and adolescents with Serious Emotional Disturbance (SED), standardized tools (i.e., the Preschool and Early Childhood Functional Assessment Scale [PECFAS], the Child Adolescent Functional Assessment Scale [CAFAS], etc.) are utilized.
- For children and adolescents with intellectual or developmental disability, standardized tools to identify functional abilities, adaptive behavior/global functioning, and level of support needs (i.e., Developmental Disabilities Children's Global Assessment Scale [DD-CGAS], Vineland, Supports Intensity Scale – Children's Version [SIS-C], etc.) are utilized.
- For adults with mental health and co-occurring mental health and substance use disorder related needs, LOCUS is applied. For adults with intellectual or developmental disability-related needs, Supports Intensity Scale – Adult Version [SIS-A] is used. For adults presenting with needs only involving substance use disorders, the GAIN-I core assessment is utilized as it directly supports the ASAM level of care criteria that this service system is based on.

Re-evaluation for eligibility is conducted annually. Formal review of the Individual Plan of Service (IPOS) will occur no less than annually with the beneficiary and any other person chosen to participate by the beneficiary or guardian. BPHASA will make determination of continuing eligibility based on evidence provided by the PIHP and an independent evaluation that the beneficiary still meets the needs-based criteria.

17.2 Definitions of Goals That Meet the Intents and Purpose of Behavioral Health 1915(i) State Plan Amendment (SPA) Supports and Services

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by BH 1915(i) SPA supports and services unless there is documentation that health

and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to ensure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether BH 1915(i) SPA supports and services alone, or in combination with State Plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in their community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the BH 1915(i) SPA context means how the individual defines the extent of such freedom for themselves during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use BH 1915(i) SPA supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.3 Criteria for Authorizing BH 1915(i) SPA Supports and Services

The authorization and use of Medicaid funds for any of the BH 1915(i) SPA supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter;
- The service(s) having been identified during person-centered planning;

- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's individual plan of service; and
- Additional criteria indicated in certain BH 1915(i) SPA service definitions, as applicable.

Decisions regarding the authorization of a BH 1915(i) SPA service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The BH 1915(i) SPA supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in their network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Refer to the Behavioral Health Code Charts and Provider Qualifications document for supports and services provider qualifications. The Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

17.4 BH 1915(i) SPA Supports and Services

The BH 1915(i) SPA supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.4.A. Community Living Supports (CLS)

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

- meal preparation
- laundry
- routine, seasonal, and heavy household care and maintenance
- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- CLS staff providing assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services
  - Reminding, observing and/or monitoring of medication administration
  - Staff assistance with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or

indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving CLS.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help services when the beneficiary's need for this assistance has been officially determined to exceed the allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.

17.4.B. Enhanced Pharmacy

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:

- A history of aspiration pneumonia, or
- Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

17.4.C. Environmental Modifications

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in the pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.

Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over their environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).

The PIHP must ensure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

17.4.D. Family Support and Training

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a beneficiary with one of these disabilities. The services target the family members who are caring for and/or living with a beneficiary receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in their ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which the beneficiary lives; or
- improving the beneficiary's inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the beneficiary at home as specified in the individual plan of service.
- Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner who has or had a child with special mental health needs provides education, training, and support, and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents/family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.

17.4.E. Fiscal Intermediary Services

Fiscal Intermediary Services is defined as services that assist the beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling their individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.

17.4.F. Housing Assistance

Housing assistance enables beneficiaries to secure and/or maintain their own housing as set forth in the beneficiary's individual plan of service. Services must be provided in the home or a community setting and include the following components:

- Conducting a community integration assessment identifying the beneficiary's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for

the beneficiary, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).

- Assisting the beneficiary with finding and securing housing as needed. This may include arranging for or providing transportation.
- Assisting the beneficiary in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
- Developing an individualized community integration plan based upon the assessment as part of the overall Person-Centered Plan (PCP).
- Identify and establish short- and long-term measurable goal(s) and establish how goals will be achieved and how concerns will be addressed.
- Participating in PCP meetings at re-determination and/or revision PCP meetings as needed.
- Providing supports and interventions per the PCP (individualized community integration portion).
- Supports to assist the beneficiary in communicating with the landlord and/or property manager regarding the beneficiary's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This includes providing support/intervention for dispute resolution with the landlord/property manager.
- Housing assistance will provide supports to preserve the most independent living arrangement and/or assist the beneficiary in locating the most integrated option appropriate to the beneficiary.

Coverage excludes:

- Costs for room and board (i.e., rent, mortgage, motel/hotel stays, security deposit, etc.)
- Funding for ongoing housing costs (i.e., repairs, utility bills, insurance, taxes, appliances, etc.)

17.4.G. Respite Care Services

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, CLS, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for CLS or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., CLS) or service through other programs (e.g., school).
- Beneficiaries who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the beneficiary is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children with Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix for additional information.)

If an adult beneficiary living at home is receiving home help services and has hired their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp
- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
- nursing homes
- hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

17.4.H. Skill-Building Assistance

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Skill-building assistance consists of activities identified in the individual plan of services that assist a beneficiary to increase their economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services occur in community-based integrated settings and provide knowledge and specialized skill development and/or supports to achieve specific outcomes consistent with the beneficiary's identified goals with the purpose of furthering habilitation goals that will lead to greater opportunities of community independence, inclusion, participation, and productivity. Refer to the Home and Community Based Services chapter for further detail.

Services include:

- Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills.
- Activities that support a beneficiary to attain and retain Individual Competitive Integrated Employment (ICIE) are time-limited and include work pathway services in the community in which a beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.
- Developing and teaching skills that lead to ICIE including, but not limited to, ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety; and mobility training. May also provide learning and work experiences, including volunteering, where the beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in ICIE. Such employment related services are expected to occur over a defined period of time, with specific employment-related goals and outcomes to be achieved as determined by the beneficiary's individual plan of service.
- Participation in skill-building is not a required prerequisite for ICIE or receiving supported employment services.

Skill-building service components needed for each beneficiary are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.).

If a beneficiary has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter of the MDHHS Medicaid Provider Manual.

17.4.I. Specialized Medical Equipment and Supplies

Specialized Medical Equipment and Supplies include an item or set of items that enable the individual to increase their ability to perform activities of daily living (ADL) with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which they live. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Items necessary for independent living (e.g., Lifeline, sensory integration equipment, electronic devices for emergencies/personal emergency response systems [PERS], etc.)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of equipment and supply items
- Repairs to covered supplies and equipment that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- Educational supplies required to be provided by the school.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of items, there must be documentation in the individual plan of services that the specialized equipment and supplies continues to be medically necessary. All applicable warranty and insurance coverages must be sought and denied before repairs are covered. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

17.4.J. Supported/Integrated Employment Services

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Supported/integrated employment services are services that are provided in a variety of community settings for the purposes of supporting beneficiaries in obtaining and sustaining ICIE. ICIE refers to full- or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are often customized, and are aimed to meet a beneficiary's personal and career goals and outcomes identified in the IPOS. Services may be provided continuously, intermittently, or on behalf of a beneficiary. Services may be delivered to promote community inclusion and competitive integrated employment.

Coverage includes:

- Job-related discovery, person-centered employment/career planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systematic instruction, job coaching, benefits and work incentives planning and management, asset development, career advancement services, career planning that supports the beneficiary to make informed choices about ICIE or self-employment. The outcome of this service is sustained ICIE at or above the minimum wage in an integrated setting in the general workforce and in a job that meets personal and career goals as outlined in the beneficiary's IPOS.

Supported employment services include the following categories:

- Individual supported employment supports to attain or sustain paid employment at or above the minimum wage, and career development in an integrated, competitive setting in the general workforce in a job that meets personal and career goals.
- Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings.
- Small group supported employment support are services and training activities, provided in typical business, industry and community settings for groups of two to six workers with disabilities, paying at least minimum wage that leads to ICIE. The purpose of

funding for this service is to support sustained paid employment and work experience that leads to ICIE. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities. Small group supported employment must promote integration into the workplace and interaction between workers with disabilities and people who do not have disabilities. Participation in small group supported employment is not a required prerequisite for ICIE or receiving supported employment services.

- Supported/integrated employment service components needed for each beneficiary are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under IDEA (20 U.S.C. 1401 et seq.).
- If a beneficiary has a need for transportation to participate, maintain, or access the supported/integrated employment services, the same service provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter.

17.4.K. Vehicle Modification

Vehicle modifications include adaptations or alterations to an automobile or van that is the beneficiary's primary means of transportation in order to accommodate the special and medical needs of the beneficiary. These adaptations must be specified in the IPOS and enable the beneficiary to integrate more fully into the community and to ensure the health, welfare and safety of the beneficiary. All items must be ordered by a physician on a prescription as defined within the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to a vehicle;
- Assessments (by an appropriate health care professional) and specialized training needed in conjunction with the use of the adaptations, as well as alterations, will be considered as part of the cost of the services.

Coverage excludes:

- The purchase or lease of a vehicle;
- Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the beneficiary;
- Regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modification(s).

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. In order to cover repairs of vehicle modifications, there must be documentation in the IPOS that the alterations continue to be medically

necessary. All applicable warranty and insurance coverages must be sought and denied before authorization is approved to pay for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

17.5 Electronic Visit Verification

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. PCS provided through Behavioral Health programs must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age diagnosed with Autism Spectrum Disorder (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, to correct or ameliorate any physical or behavioral conditions so that health problems are averted or diagnosed and treated as early as possible.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 Comprehensive Diagnostic Evaluations

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a board certified and licensed behavior analyst (BCBA/LBA) to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a masters level, fully licensed clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by following best practice standards. The differential diagnosis of ASD and related conditions requires multimodal assessment and integration of clinical information. This is a complex assessment procedure in which clinicians must integrate data from caregiver reports, records (e.g., medical, school, other evaluations), collateral reports (e.g., teachers, other treatment providers), data gathered from utilization of standardized psychological tools (e.g., developmental, cognitive, adaptive assessment), and the observational assessment to determine diagnostic and clinical impressions. The utilization of multiple data modes and sources improves the reliability of ASD diagnosis. No one piece of data determines the ASD diagnosis, and evaluators should consider the accuracy of data and confounding factors that may impact data obtained (e.g., parent who seems to be overly negative about the child, child who was intensely shy during observational assessment).

18.4 Medical Necessity Criteria

Medical necessity and recommendation for BHT services are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:

   1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.

   2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.

   3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.

B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:

   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).

   2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).

   3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).

   4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).

18.5 Determination of Eligibility for BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing valid evaluation tools. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have

marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

To be eligible for BHT, the following criteria must be met:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
- Child is medically able to benefit from the BHT treatment.
- Treatment outcomes are expected to develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD. Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers and clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner.
- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 Prior Authorization

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.

18.7 Re-evaluation

Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers.

18.8 Transition and Discharge Criteria

The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process.

Discharge from BHT services should be reviewed and evaluated by a qualified BHT professional for children who meet any of the following criteria:

- The individual has achieved treatment goals and less intensive modes of services are medically necessary and/or appropriate.
- The individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The individual, family, or authorized representative(s) is interested in discontinuing services.
- The individual has not demonstrated measurable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through the successive authorization periods.
- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
- The services are no longer medically necessary, as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the BHT service.

18.9 BHT Services

18.9.A. Behavioral Assessment

A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a board certified and licensed behavior analyst (BCBA/LBA). Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a BCBA/LBA.

18.9.B. Behavioral Intervention

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings.

BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

18.10 BHT Service Level

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within the individual's community for an appropriate period of time, depending on the needs of the individual and their family or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the individual's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant responsibilities of educational or other authorities. Each individual's IPOS must specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the individual through a local education agency. The recommended service level, setting(s), and duration will be included in the individual's IPOS, with the planning team and the family or authorized representative(s) reviewing the IPOS no less than annually and, if indicated, adjusting the service level and setting(s) to meet the individual's changing needs. The service level includes the number of hours of intervention provided to the individual. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each individual and should reflect the goals of treatment, specific needs of the individual, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

18.11 BHT Service Evaluation

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBAs/LBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition.

Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

18.12 BHT Service Provider Qualifications

BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA/LBA or a Master's prepared QBHP.) These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA/LBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.

18.12.A. BHT Supervisors

Board Certified Behavior Analyst-Doctoral (BCBA-D/LBA) or Board Certified Behavior Analyst (BCBA/LBA)	• Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). Licensed through the Michigan Licensing and Regulatory Authority (LARA). • Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
Licensed Psychologist (LP or LLP)	• Must be certified and licensed as a BCBA/LBA by September 30, 2025. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements. LLP means a masters level psychologist licensed by the State of Michigan. • Education and Training: Minimum of a doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: ➢ Ethical considerations. ➢ Definitions and characteristics; and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions. ➢ Measurement of behavior, and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports.

	• A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA/LBA to discuss the caseload, progress, and treatment of the child with ASD.
Board Certified Assistant Behavior Analyst (BCaBA)	• Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA. • Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence. Licensed through LARA. • Other Standard: Works under the supervision of the BCBA/LBA.
Qualified Behavioral Health Professional (QBHP)	• Must be licensed and certified as a BCBA/LBA by September 30, 2025. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Must be certified as a BCBA/LBA within two years of successfully completing ABA graduate coursework. • Education and Training: QBHP must meet one of the following state requirements: ➢ Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. ➢ Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of a BCBA/LBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level (i.e., completion of three BACB evaluated graduate courses or BACB verified course sequences meeting specific standards toward certification) from an accredited university in at least three of the six following areas: ♦ Ethical considerations. ♦ Definitions and characteristics; and principles, processes and concepts of behavior. ♦ Behavioral assessment, and selecting interventions outcomes and strategies. ♦ Experimental evaluation of interventions. ♦ Measurement of behavior, and developing and interpreting behavioral data. ♦ Behavioral change procedures and systems supports.
Behavior Technician or Registered Behavior Technician (RBT)	• Services Provided: Behavioral intervention. • License/Certification: A license or certification is not required. • Education and Training: Will receive BACB approved Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT

	services (BCBA/LBA, BCaBA, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services. • Works under the supervision of the BCBA/LBA or other professional (BCaBA, or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment. • Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.

18.13 ABA RATE [SUBSECTION ADDED 7/1/2025]

All PIHPs will reimburse BHT-ABA services at a minimum to the rate outlined with the most recent executed PIHP contract. **(text added per bulletin MMP 24-51)**

SECTION 19 – SUBSTANCE USE DISORDER HEALTH HOME

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan and Alternative Benefit Plan Amendments, the purpose of this policy is to provide for the coverage and reimbursement of Substance Use Disorder Health Home (SUDHH) services. This policy is effective for dates of service on and after October 1, 2024. The policy applies to Fee-for-Service (FFS) and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who meet SUDHH eligibility criteria. In addition to this policy, an operations guide for providers called the Substance Use Disorder Health Home (SUDHH) Handbook is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Note: Continuation of the SUDHH policy/benefit after ten (10) quarters of the effective date is subject to Michigan Department of Health and Human Services (MDHHS) review and approval.

Note: Prepaid Inpatient Health Plan (PIHP) serves as the Lead Entity (LE) for the SUDHH.

19.1 GENERAL INFORMATION

Effective October 1, 2024, MDHHS implemented a care management and care coordination primary care Health Home benefit called the Substance Use Disorder Health Home (SUDHH) (previously referred to as the Opioid Health Home [OHH]). The goals of the program are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting.

19.2. BENEFICIARY ELIGIBILITY

Eligible beneficiaries cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of alcohol, stimulant, and opioid use disorder. Beneficiaries must also be at risk of developing mental health conditions, asthma, diabetes, heart disease, body mass index (BMI) over 25, or chronic obstructive pulmonary disease (COPD).

19.3 BENEFICIARY ENROLLMENT

19.3.A. ENROLLMENT PROCESSES

Potential Substance Use Disorder Health Home (SUDHH) enrollees will be identified using a multifaceted approach. The Michigan Department of Health and Human Services (MDHHS) will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The PIHP will identify potential enrollees from the WSA and coordinate with a health home partner (HHP) to fully enroll the Medicaid beneficiary into the SUDHH benefit. The selection of a HHP is optional, the beneficiary may have other choices of HHPs, and the beneficiary may disenroll from the benefit at any time. Enrolling into the health home benefit does not restrict access to other providers nor does it limit access to other Medicaid benefits. Enrollment into health home is voluntary and the potential enrollee must agree to receive health home services and provide consent that is maintained in the enrollee's health record.

PIHPs will provide information about the SUDHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. PIHPs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the SUDHH.

- **PIHP Identification of Potential Enrollees**

  The PIHP will be responsible for identifying potential enrollees that have a qualifying SUD diagnosis in the WSA to a HHP and provide information regarding SUDHH services to the Medicaid beneficiary in coordination with the HHP.

- **Provider Recommended Identification of Potential Enrollees**

  HHPs are permitted to recommend potential enrollees for the SUDHH benefit via the WSA. HHPs must provide documentation that indicates whether a potential SUDHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of an individualized care plan. The PIHP must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

19.3.B. Beneficiary Consent

Potential enrollees must provide HHPs a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (MDHHS-5515) to receive the SUDHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. (The MDHHS-5515 can be found on the MDHHS website. Refer to the Directory Appendix for website information.) The form is also available at the designated HHP's office and on the PIHP's website. HHPs are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the PIHP. All documents must be maintained in compliance with MDHHS record-keeping requirements.

19.3.C. SUDHH Benefit Plan Assignment

Once enrolled, the beneficiary is assigned to the Substance Use Disorder Health Home (SUDHH) benefit plan associated with their Medicaid member ID in the Community Health Automated Medicaid Processing System (CHAMPS). It is incumbent upon SUDHH providers to verify a beneficiary's SUDHH benefit plan assignment prior to rendering services. Beneficiaries without the SUDHH benefit plan assignment are not eligible for SUDHH payment.

19.3.D. Beneficiary Disenrollment

Beneficiaries may opt-out or disenroll from the SUDHH benefit at any time. Beneficiaries who opt-out of enrollment initially may elect to enroll later contingent on meeting eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other entitled medically necessary Medicaid services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries are categorized into one of the following two groups which have unique disenrollment processes:

- Beneficiaries who moved out of the state of Michigan, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will have their eligibility files updated per the standard MI Bridges protocol. HHPs will receive updated files accordingly.
- Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP must make at least three unsuccessful beneficiary contact attempts within six consecutive months for MDHHS to deem a beneficiary as unresponsive. For provider-recommended enrolled beneficiaries, if the beneficiary is unresponsive for three months, the PIHP must mark the beneficiary as disenrolled via the WSA via the last date of service. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment, as applicable.

19.3.E. Beneficiary Changing SUDHH Providers

While the beneficiary's stage in recovery and individualized care plan is utilized to determine the appropriate setting and HHP of care (i.e., providers within Opioid Treatment Program versus Office-Based Substance Use Disorder Treatment), beneficiaries have the option to change HHPs to the extent feasible within the regional PIHP's designated HHP network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen HHP. However, beneficiaries may change HHPs and should notify their current HHP immediately if they intend to do so. Current and future HHPs must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new HHP's appointment availability. Only one SUDHH provider may be paid per beneficiary per month for SUDHH services.

19.4 Covered Services

SUDHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of substance use disorder and comorbid physical and behavioral health conditions. These services include the following:

- **Comprehensive Care Management**, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - Development of an individualized care/treatment plan;
  - Documentation of assessment and care plan in the Electronic Health Record; and
  - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

- **Care Coordination,** including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
  - Information sharing between providers, patient, authorized representative(s), and family;
  - Resource management and advocacy;
  - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
  - Appointment-making assistance, including coordinating transportation;
  - Development and implementation of care plan;
  - Medication adherence and monitoring;
  - Referral tracking;
  - Use of facility liaisons;
  - Use of patient care team huddles;
  - Use of case conferences;
  - Tracking of test results;
  - Requiring discharge summaries;
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).
- **Health Promotion**, including but not limited to:
  - Providing patient and family activation and education;
  - Providing patient-centered training (e.g., diabetes education, nutrition education, etc.);
  - Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.);
  - Promoting healthy lifestyle interventions;
  - Encouraging a routine preventative care such as immunizations and screenings;
  - Assessing the patient and family's understanding of the health condition and motivation to engage in self-management; and

- Using evidence-based practices, to engage and help patient participate in and manage their care.

- **Comprehensive Transitional Care,** including but not limited to:
  - Connecting the beneficiary to health services;
  - Coordinating and tracking the beneficiary's use of health services through Health Information Technology (HIT) in conjunction with the PIHP Coordinator;
  - Providing and receiving notification of admissions and discharges;
  - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
  - Post-discharge outreach to ensure appropriate follow-up services for all care in conjunction with the PIHP Coordinator;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Proactive care (versus reactive care);
  - Specialized transitions when necessary (i.e., age, corrections); and
  - Home visits to ensure stability through transitions.
- **Individual and Family Support (including authorized representatives),** including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing patient and family skills and engagement;
  - Use of community supports (i.e., Community Health Workers, peer supports, peer recovery coaches, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increasing individual and family health literacy;
  - Use of advance directives, including psychiatric advance directives;
  - Contributing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.
- **Referral to Community and Social Support Services,** including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home;
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;

- Providing resource materials pertinent to patient needs;
- Assisting in obtaining other resources, including benefit acquisition;
- Providing referral to housing resources; and
- Providing referral tracking and follow-up.

19.5 Provider Eligibility Requirements

Eligible SUDHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers must complete the MDHHS Health Home Provider (HHP) Application (form MDHHS-5745), which requires attestation to the requirements cited in this policy, the State Plan Amendment, and other applicable MDHHS policies and procedures. (The MDHHS-5745 and the State Plan are available on the MDHHS website. Refer to the Directory Appendix for website information.)

19.5.A. Geographic Area

SUDHH services are available to Medicaid beneficiaries pending availability of SUDHH providers. A listing/map of counties is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

19.5.B. Provider Types

Eligible provider types for the SUDHH include Opioid Treatment Programs (OTPs) and Office-Based Substance Use Disorder Treatment (OBSUT) providers. OTPs must meet all state and federal licensing requirements. OBSUT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT. OBSUT providers may include Community Mental Health Services Programs (CMHSPs), Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, Tribal Health Centers (THCs), and individual provider practices.

19.5.C. Provider Requirements

PIHPs and providers must adhere to the requirements of the State Plan Amendment, all Medicaid statutes, policies, procedures, rules, and regulations, and the SUDHH Handbook.

Regional PIHP (per 100 patients)	• Health Home Director (0.5 FTE)
Health Home Partners (per 100 patients)	• Behavioral Health Specialist (0.25 FTE) • Nurse Care Manager (1.00 FTE) • Peer Recovery Coach, Community Health Worker (2.00-4.00 FTE) • Medical Consultant (0.10 FTE) • Psychiatric Consultant (0.05 FTE)

Contingent upon MDHHS exceptions, all providers referenced above must meet the following criteria:

Health Home Director	• Must be an administrative staff person employed by the PIHP.
Behavioral Health Specialist	• an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR • who has a bachelor's degree from an accredited four-year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR • who has a master's degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)
Nurse Care Manager	• licensed registered nurse, licensed practical nurse
Peer Recovery Coach, Community Health Worker, Medical Assistant	• Appropriate certification/training. • Must be at least 18 years of age. • Must possess high school diploma or equivalent.
Medical Consultant	• primary care physician, physician's assistant, or nurse practitioner
Psychiatric Consultant	• licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner)

In addition to the above Provider Infrastructure Requirements, eligible HHPs should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

19.6 Provider Enrollment and SUDHH Designation

All HHPs must be properly paneled with the PIHP through contract, memorandum of understanding, or a similar mechanism conveying mutual partnership to execute SUDHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the provider application (MDHHS-5745).

19.6.A. Training and Technical Assistance

MDHHS is requiring HHPs to actively participate in state- and PIHP-sponsored activities related to training and technical assistance and will also impose additional

functional provider requirements to optimize care management, coordination, and behavioral health integration.

19.6.B. Use of Applicable Health Information Technology (HIT)

MDHHS requires HHPs to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources is provided by MDHHS.

19.7 Provider Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects HHPs to establish a lasting relationship with enrolled beneficiaries. However, HHPs wishing to discontinue SUDHH services must notify the regional PIHP and MDHHS before ceasing SUDHH operations. SUDHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

19.8 SUDHH Payment

Payment for SUDHH services is contingent on designated HHPs meeting the requirements laid out in the State Plan Amendment, this policy, the provider application (MDHHS-5745), the SUDHH Handbook, and as determined by MDHHS. Failure to meet these requirements may result in loss of HHP designation.

19.8.A. General Provisions for SUDHH Payment

19.8.A.1. MDHHS to Regional PIHP

MDHHS will provide a monthly case rate to the PIHP based on attributed SUDHH beneficiaries with at least one SUDHH service. MDHHS is the PIHP to, in turn, pay HHPs a negotiated rate with a state-directed minimum payment. Any savings afforded through the provision of health home services will be shared between the PIHP and the HHPs based on defined quality metrics. Additionally, MDHHS will employ a P4P incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers are paid.

19.8.A.2. Regional PIHP to Health Home Partners

Designated HHPs must bill through their regional PIHP to receive SUDHH payment. Designated HHPs are paid one monthly case rate per beneficiary.

19.8.A.3. Pay For Performance

MDHHS will afford P4P via a 5% performance incentive to the additional per member per month case rate. The PIHP must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the timelines and processes. The State will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement

benchmarks are not met by any of the HHPs within a given performance year, the State will distribute funds based on HHPs. The funding will be distributed equally among regions that maintain a recoupment rate less than 45% during the performance year. Subsequent performance years will operate in accordance with this structure.

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the SUDHH Handbook.

Note: Payment for SUDHH services is in addition to the existing FFS payments, encounters, or daily rate payments for direct clinical services. The MDHHS payment methodology is designed to only reimburse for the cost of the HHP staff for the delivery of SUDHH services that are not covered by any other currently available Medicaid reimbursement mechanism.

19.8.B. Recoupment of Payment

The monthly payment is contingent upon an SUDHH beneficiary receiving an SUDHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive an SUDHH service during the calendar month. The recoupment lookback will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example: in January, MDHHS would look back at the payment made in July), CHAMPS will conduct an automatic recoupment process that will look for an approved encounter code (refer to the SUDHH Handbook) which documents that the SUDHH provided at least one of the six core SUDHH services (refer to the Covered Services subsection) during the calendar month in question. If a core SUDHH service is not provided during a month, that month's payment will be subject to recoupment by MDHHS. Once a recoupment has occurred, there shall be no further opportunity to submit a valid SUDHH encounter code and/or claim for the month that has a payment recouped.

Additional details regarding payment recoupment, including the recoupment schedule and other reasons for recoupment, can be found in the SUDHH Handbook.

SECTION 20 – BEHAVIORAL HEALTH HOME

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of the Behavioral Health Home (BHH) is to provide for the coverage and reimbursement of six required Behavioral Health Home services. This benefit is effective for dates of service on and after October 1, 2020. The benefit applies to Fee-for-Service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, Freedom of Choice, or MIChild who meet BHH eligibility criteria. In addition, MDHHS created a companion operation guide for providers called the Behavioral Health Home (BHH) Handbook which is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Note: Continuation of the BHH policy/benefit after eight (8) quarters of the effective date is subject to MDHHS review and approval.

Note: The Prepaid Inpatient Health Plan (PIHP) serves as the Lead Entity (LE) for the BHH.

20.1 GENERAL INFORMATION

The BHH provides comprehensive care management and care coordination services to beneficiaries with a select serious mental illness/serious emotional disturbance. The goals of the benefit are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical, behavioral, and social services. MDHHS expects the benefit will enhance beneficiary outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a behavioral health care setting.

20.2 BENEFICIARY ELIGIBILITY

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom of Choice, or MIChild who have a diagnosis of a Serious Mental Illness or Serious Emotional Disturbance.

20.3 BENEFICIARY ENROLLMENT

20.3.A. ENROLLMENT

Potential BHH enrollees will be identified using a multifaceted approach. MDHHS will provide a generated list that will pull potential enrollees from MDHHS administrative claims data into the Waiver Support Application (WSA) monthly. The PIHP will identify potential enrollees from the WSA and coordinate with a Health Home Partner (HHP) to fully enroll the Medicaid beneficiary into the BHH benefit.

PIHPs will provide information about the BHH to all potential enrollees through community referrals, peer support specialist networks, other providers, courts, health departments, law enforcement, and other community-based settings. PIHPs will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the BHH.

20.3.B. PIHP Identification of Potential Enrollees

The PIHP will be responsible for identifying potential enrollees that have a qualifying BHH diagnosis in the WSA to a prospective HHP and provide information regarding BHH services to the Medicaid beneficiary in coordination with the HHP.

20.3.C. Provider Recommended Identification of Potential Enrollees

HHPs are permitted to recommend potential enrollees for the BHH benefit via the WSA. BHH providers must provide documentation that indicates whether a potential BHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of a Behavioral Health Home care plan. The PIHP must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.

20.3.D. Beneficiary Consent

Beneficiaries must provide BHH providers a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (MDHHS-5515) to receive the BHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. The MDHHS-5515 can be found on the MDHHS website. (Refer to the Directory Appendix for website information.) The form is also available at the designated HHP's office and on the PIHP's website. HHPs are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the PIHP. All documents must be maintained in compliance with MDHHS record-keeping requirements.

20.3.E. BHH Benefit Plan Assignment

Once enrolled, the beneficiary is assigned to the behavioral health home benefit plan (HHBH) associated with their Medicaid member ID in the Community Health Automated Medicaid Processing System (CHAMPS). It is incumbent upon BHH providers to verify a beneficiary's HHBH benefit plan assignment prior to rendering services. Beneficiaries without the HHBH benefit plan assignment are not eligible for BHH payment.

20.3.F. Beneficiary Disenrollment

Failure to verify consent or diagnostic eligibility will prevent the Medicaid beneficiary from enrolling into the BHH benefit. Medicaid beneficiaries may opt-out (disenroll) from the BHH at any time with no impact on their eligibility for other Medicaid services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into one of the following two groups, which have unique disenrollment processes:

- Beneficiaries who have moved out of an eligible geographic area, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will

have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.

- Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP or HHP must make at least three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment for a year or until eligibility changes.

20.3.G. Beneficiary Changing BHH Providers

While the beneficiary's individualized care plan will be utilized to determine the appropriate setting and BHH provider of care, beneficiaries will have the ability to change BHH providers to the extent feasible within the PIHP's designated BHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen BHH provider. However, if a beneficiary decides to change BHH providers, they should notify their current BHH provider immediately if they intend to do so. The current and future BHH providers must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new BHH provider's appointment availability. Only one BHH provider may be paid per beneficiary per month for health home services.

20.4. Covered Services

BHH services will provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. BHH must provide the following six core services, linked as appropriate by health information technology (HIT):

- Comprehensive Care Management, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - Development of an individualized care plan;
  - Documentation of assessment and behavioral health home care plan in the Electronic Health Record (EHR); and
  - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.
- Care Coordination, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;

- Information sharing between providers, beneficiary, authorized representative(s), and family;
- Resource management and advocacy;
- Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
- Appointment-making assistance, including coordinating transportation;
- Development and implementation of individualized care plan;
- Medication adherence and monitoring;
- Referral tracking;
- Use of facility liaisons;
- Use of patient care team huddles;
- Use of case conferences;
- Tracking of test results;
- Requiring discharge summaries;
- Providing beneficiary and family activation and education;
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

▪ Health Promotion, including but not limited to:

- Providing beneficiary and family activation and education;
- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.);
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder (SUD) treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.);
- Promoting healthy lifestyle interventions;
- Encouraging routine preventative care such as immunizations and screenings;
- Assessing the beneficiary's and family's understanding of the health condition and motivation to engage in self-management; and
- Using evidence-based practices to engage and help the beneficiary participate in and manage their care.

- Comprehensive Transitional Care, including but not limited to:
  - Connecting the beneficiary to health services;
  - Coordinating and tracking the beneficiary's use of health services through HIT in conjunction with the PIHP Coordinator;
  - Providing and receiving notification of admissions and discharges;
  - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
  - Post-discharge outreach to ensure appropriate follow-up services for all care in conjunction with the PIHP Coordinator;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Proactive care (versus reactive care);
  - Specialized transitions when necessary (i.e., age, corrections); and
  - Home visits to ensure stability through transitions.
- Individual and Family Support Services (including authorized representatives), including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing beneficiary and family skills and engagement;
  - Use of community supports (i.e., Community Health Workers [CHW], peer supports, peer recovery coaches, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increasing individual and family health literacy;
  - Use of advance directives, including psychiatric advance directives;
  - Contributing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.
- Referral to Community and Social Support Services, including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home;
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;
  - Providing resource materials pertinent to the beneficiary's needs;
  - Assisting in obtaining other resources, including benefit acquisition;
  - Providing referral to housing resources; and
  - Providing referral tracking and follow-up.

20.5 Provider Eligibility Requirements

Eligible BHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in the BHH Handbook. Additionally, eligible providers will sign the Health Home Provider (HHP) Application (form MDHHS-5745) attesting to meet the requirements in the policy, the State Plan Amendment (SPA), and other applicable MDHHS policies and procedures. HHPs must contract with the PIHP.

20.5.A. Geographic Area

BHH services are available to Medicaid beneficiaries who reside in select counties and who meet all other eligibility criteria. A listing/map of counties is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

20.5.B. Provider Types

The PIHP will be responsible for providing health home services in partnership with community-based HHPs. PIHPs currently contract with the State of Michigan for Medicaid services. HHPs are permitted to recommend prospective BHH beneficiaries for enrollment into the BHH via the PIHP. BHH providers must provide documentation that indicates whether a prospective BHH beneficiary meets all eligibility for the benefit, including diagnostic verification, obtaining consent (MDHHS-5515), and establishment of a care plan. The PIHP must review and process all recommended enrollments in the WSA.

20.5.C. Provider Requirements

PIHPs must adhere to the BHH contractual and policy requirements with MDHHS. HHPs must meet the requirements indicated in the MDHHS-5745 with MDHHS and the PIHP requirements. PIHPs and HHPs must adhere to the requirements of the SPA, all Medicaid statutes, policies, procedures, rules, and regulations, and the BHH Handbook.

20.5.D. Provider Infrastructure Requirements

HHPs, through the PIHP, will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The requirements will span two settings – the PIHP and the HHP providers. Each setting will have its own unique set of requirements commensurate with the scope of their operations to reflect beneficiary needs. The staffing structure below is based on 100 beneficiaries enrolled in the health home.

Regional PIHP (per 100 beneficiaries)	▪ Health Home Director (.25 FTE)
Health Home Partners (per 100 beneficiaries)	▪ Behavioral Health Specialist (0.25 FTE) ▪ Nurse Care Manager (1.00 FTE) ▪ Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist, Community Health Worker, Medical Assistant (3.00-4.00 FTE) ▪ Medical Consultant (.10 FTE) ▪ Psychiatric Consultant (.10 FTE)

Contingent upon MDHHS exceptions, all providers referenced above must meet the following criteria:

Nurse Care Manager	▪ Must be a licensed registered nurse in Michigan. ▪ Shall be a licensed registered nurse (RN) or licensed practical nurse (LPN). ▪ LPNs must meet the following requirements to fill this role: ➢ minimum of one year experience in a managed care setting preferred, and ➢ a minimum of three to five years medical nursing, surgical nursing and/or nursing in the acute care setting. ▪ A portion of the Nurse Care Manager FTE must include an RN to complete assessments, perform care planning, coordinate complex patients, and provide high-level education as needed.
Behavioral Health Specialist	▪ Must have a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; **OR** ▪ who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; **OR** ▪ an individual who has a Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school.
Peer Support Specialist, Peer Recovery Coach, Youth Peer Support Specialist	▪ Has received public mental health services in the past or is currently receiving services. ▪ Provide at least 10 hours per week of services described above with supported documentation written in the individualized care plan. ▪ Meet the MDHHS application approval process for specialized training and certification requirements.
Community Health Worker (CHW)	▪ Must be at least 18 years of age. ▪ Must possess a high school diploma or equivalent. ▪ Must be supervised by licensed professional members of the care team. ▪ Must complete a CHW Certificate Program or equivalent.

Medical Assistant	▪ Must be at least 18 years of age. ▪ Must possess a high school diploma or equivalent. ▪ Must possess appropriate education, certification, and/or training.
Health Home Director	▪ Must be an administrative staff person employed by the PIHP.
Access to a Medical Consultant (can be off-site)	▪ Must be a primary care physician, physician assistant, or certified nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable).
Access to a Psychiatric Consultant (can be off-site)	▪ Must be a licensed psychiatrist or doctoral-level psychologist in Michigan.

In addition to the above Provider Infrastructure Requirements, eligible BHH providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

20.6 Provider Enrollment and BHH Designation

All HHPs must be properly paneled with the PIHP through contract, memorandum of understanding, or a similar mechanism conveying mutual partnership to execute BHH services. Moreover, all HHPs must sign and attest to the requirements set forth in the MDHHS-5745.

20.6.A. Training and Technical Assistance

MDHHS requires HHPs to actively participate in state- and PIHP-sponsored activities related to training and technical assistance and will also impose additional functional provider requirements to optimize care management, coordination, and behavioral health integration.

20.6.B. Use of Applicable Health Information Technology (HIT)

MDHHS requires BHH providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources is provided by MDHHS.

20.7 Provider Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects HHPs to establish a lasting relationship with enrolled beneficiaries. However, HHPs wishing to discontinue BHH services must notify the regional PIHP and MDHHS at least six months in advance of ceasing BHH operations. BHH services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

20.8 BHH Payment

MDHHS will provide a monthly case rate to the PIHP based on the number of BHH beneficiaries with at least one BHH service in a month. The PIHP will reimburse the HHP for delivering health home services. Additionally, MDHHS will employ a pay-for-performance (P4P) incentive that will reward providers based on outcomes. MDHHS will only claim federal match for P4P incentive payments after P4P qualifications have been met and providers have been paid.

20.8.A. BHH Case Rates to the PIHP

MDHHS will maintain a fee schedule of the BHH case rate on the MDHHS BHH website, in the BHH Handbook, and in the BPHASA Service Encounter Coding Chart. MDHHS will review the case rates at least annually and make updates as appropriate.

20.8.B. PIHP Payment to Health Home Partners

MDHHS will provide a monthly case rate to the PIHP based on the number of BHH beneficiaries with at least one BHH service during a calendar month. The PIHP will reimburse the HHP for delivering health home services. Depending on the current services provided by the HHP, the PIHP may negotiate a rate with the HHP for value-based payment while following the guidelines below, requirements in the approved SPA, policy, and the BHH Handbook.

20.8.C. Pay-for-Performance

MDHHS will afford P4P via a 5% performance withhold. The PIHP must distribute P4P monies to HHPs that meet the quality improvement benchmarks in accordance with the approved SPA, policy, and BHH Handbook. MDHHS will only claim federal match once it determines quality improvement benchmarks have been met and providers have been paid. If quality improvement benchmarks are not met by any of the HHPs within a given performance year, the withhold will be reserved by MDHHS and reinvested for BHH monthly case rate payments. Subsequent performance years will operate in accordance with this structure. The methodology for metrics, specifications, and distribution will be maintained on the MDHHS BHH website and in the BHH Handbook.

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the BHH Handbook.

Note: Payment for BHH services is in addition to existing FFS payments, encounters, or daily rate payments for direct clinical services. The MDHHS payment methodology is designed to only reimburse for the cost of the BHH provider staff for

the delivery of BHH services that are not covered by any other currently available Medicaid reimbursement mechanism.

20.8.D. Recoupment of Payment

The monthly payment is contingent upon a BHH beneficiary receiving a BHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive a BHH service during the calendar month. The recoupment lookback will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example: in January, MDHHS would look back at the month of July's payment), CHAMPS will conduct an automatic recoupment process that will look for an approved encounter code that documents that the HHP provided at least one of the six core BHH services during the calendar month in question. If a core BHH service is not provided during a month, that month's payment will be subject to recoupment by MDHHS. Once a recoupment has occurred, there shall be no further opportunity to submit a valid BHH encounter code and/or claim for the month that has a payment recouped.

Additional details regarding payment recoupment, including the recoupment schedule and other reasons for recoupment, can be found in the BHH Handbook.

SECTION 21 – CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION

21.1 GENERAL INFORMATION

The CMS CCBHC Demonstration requires states and their certified CCBHC sites to provide a robust set of coordinated, integrated, and comprehensive services to all persons with any mental illness or substance use disorder (SUD) diagnosis. Moreover, the demonstration requires and emphasizes 24/7/365 crisis response services (e.g., mobile crisis services). Other critical elements include, but are not limited to, strong accountability in terms of financial and quality metric reporting; formal coordination with primary and other care settings to provide intensive care management and transitions; linkage to social services, criminal justice/law enforcement, and educational systems; and an emphasis on providing services to veterans and active-duty service members.

To account for these requirements, the state must create a prospective payment system (PPS) reimbursement structure that finances CCBHC services at an enhanced payment rate to properly cover costs and offer greater financial predictability and viability. The PPS is integral to sustaining expanded services, investments in the technological and social determinants of care, and serving all eligible Michigan residents regardless of insurance or ability to pay.

MDHHS developed a companion operational guide for providers called the CCBHC Demonstration Handbook which is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

21.2 ELIGIBILITY

21.2.A. SITE ELIGIBILITY

Per CMS directive, states have the flexibility to determine which behavioral health providers can participate in the CCBHC Demonstration. Sites must meet all requirements as outlined in the CCBHC Demonstration Handbook and be certified by MDHHS to be designated as a CCBHC demonstration site.

21.2.B. CCBHC SERVICE RECIPIENT ELIGIBILITY

Any person with a mental health or SUD International Classification of Diseases (ICD)-10 diagnosis code is eligible for CCBHC services. CCBHCs must serve all individuals, regardless of county of residency, insurance coverage, age, severity of need, or ability to pay.

Exceptions to the diagnostic requirement are:

- Persons in crisis: People in crisis are eligible to receive CCBHC crisis services even if it is determined during the CCBHC crisis service that the person does not have a mental health or SUD diagnosis.
- Persons being assessed/screened for mental health and/or SUD diagnoses: People without a current mental health and/or SUD diagnosis are eligible to receive CCBHC screening and assessment services even if these services do not result in a diagnosis. If the screening/assessment does not result in a mental health and/or SUD diagnosis, the person is not eligible to receive subsequent CCBHC services unless they are:

1) in crisis as described above; or 2) later found to have a mental health and/or SUD diagnosis.

21.2.C. Residency

CCBHCs must serve all individuals regardless of residency. CCBHCs may define service catchment areas for targeted outreach that correspond directly to the required annual needs assessment. (Refer to the Program Requirements section of this chapter for additional information.) For individuals residing out of state, CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services and should have protocols developed for coordinating care across state lines.

21.3 Enrollment [Change Made 4/1/2025]

All eligible Medicaid beneficiaries will be automatically enrolled into the CCBHC benefit plan. Additional beneficiaries may be added as appropriate. **(revised 4/1/2025)** Non-Medicaid individuals are not automatically enrolled in the CCBHC benefit plan but should be tracked using encounter reporting and other methods outlined in the CCBHC Demonstration Handbook. MDHHS reserves the right to review and verify all enrollments.

21.4 Certification Requirements

CCBHC demonstration clinics must complete the MDHHS certification process to become a CCBHC under the CMS CCBHC Demonstration. During the certification process, CCBHC clinics will provide justification of meeting CCBHC criteria defined by Substance Abuse and Mental Health Services Administration (SAMHSA) and MDHHS by submitting supporting documentation verifying that standards have been met.

In accordance with the Protecting Access to Medicare Act of 2014 (PAMA), certification criteria address the following broad elements.

21.4.A. Staffing Requirements

Staffing requirements include criteria that staff have diverse disciplinary backgrounds, have necessary state required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population.

21.4.B. Availability and Accessibility of Services

Availability and accessibility of services includes crisis management services that are available and accessible 24 hours per day, the use of a sliding scale for payment, and no rejection for services or limiting of services based on an individual's ability to pay or county of residence.

21.4.C. Care Coordination

Care coordination includes requirements to coordinate care across settings and providers to ensure seamless transitions for individuals across the full spectrum of health services, including acute, chronic, and behavioral health needs. Care coordination requirements shall include, at minimum, partnerships or formal contracts with federally-qualified health centers (FQHCs) (and, as applicable, rural health clinics [RHCs]) to provide FQHC services (and, as applicable, RHC services) to the extent such services are not provided directly through the CCBHC; inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs, other community or regional services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, state licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services; Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the department as defined in section 1801 of Title 38, United States Code; and inpatient acute care hospitals and hospital outpatient clinics.

21.4.D. Scope of Services

The CCBHC scope of services includes provision (in a manner reflecting person-centered care) of the nine core CCBHC services outlined in the CCBHC Service Requirements subsection of this policy. Services may be provided directly by the CCBHC or through formal relationships with DCOs. Required evidence based practices and expectations around service delivery are outlined in the CCBHC Demonstration Handbook.

21.4.E. Quality and Other Reporting

CCBHCs must collect, report, and track encounter, outcome, and quality data, and other data as federally required or requested by MDHHS. Measures and specifications for reporting are listed in the CCBHC Demonstration Handbook.

21.4.F. Organization Authority, Governance, and Accreditation

The CCBHC must meet one of the following criteria:

- a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code;
- a part of a local government behavioral health authority (which includes all forms of CMHSPs);
- an organization operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 United States Code [USC] 450 et seq.); or

- an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 USC 1601 et seq.).

A detailed description of all certification requirements and standards can be found in the CCBHC Demonstration Handbook.

21.5 Service Requirements

CCBHCs, directly or through DCOs, must provide a set of nine comprehensive services to address the complex and myriad needs of persons with mental health or SUD diagnoses services. These services include the following:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

Services should be provided in accordance with requirements detailed in this Manual unless otherwise specified in the CCBHC Demonstration Handbook. CCBHCs must comply with all Medicaid laws, regulations, and policies when providing services to CCBHC recipients and must adhere to the Michigan Mental Health Code for all CCBHC service recipients as applicable.

21.6 Designated Collaborating Organization (DCO)

A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC.

21.6.A. Agreements with CCBHCs [Change Made 4/1/2025]

A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. CCBHC maintains responsibility for ensuring the DCO complies with CCBHC requirements, including compliance with contracted services delivered and financial components of the demonstration. **(revised 4/1/2025)**

21.6.B. Payment for DCOs

Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS. Payment will be provided directly to the DCO from the CCBHC based on agreed upon contractual service rates.

21.7 Payment Methodology

MDHHS will utilize the prospective payment system 1 (CC PPS-1) methodology in which CCBHCs receive a daily clinic-specific rate based on the average expected daily cost to deliver CCBHC services. MDHHS will also employ a Quality Bonus Payment (QBP) that will reward CCBHCs based on attainment of outcomes.

CCBHCs must submit valid CCBHC Encounter Codes cited in Appendix A of the CCBHC Demonstration Handbook with a corresponding T1040 service encounter code to receive payment.

21.7.A. PPS-1 Rates

MDHHS will utilize pertinent cost and utilization data from the submitted annual Cost Report to develop clinic-specific PPS-1 rates. Rates may be updated each demonstration year based on Cost Report data, the appropriate Medicare Economic Index (MEI) adjustment, or as otherwise permitted under federal guidance. Rate updates will be documented in applicable rate certification materials.

21.7.B. Quality Bonus Payments

MDHHS will afford Quality Bonus Payments (QBPs) based on providers meeting CMS-defined quality benchmarks. The methodology, specifications, and distribution will be maintained in the CCBHC Demonstration Handbook.

21.8 Reporting Requirements [Change Made 4/1/2025]

CCBHCs are responsible for the reporting of encounter data, clinical outcomes data, quality data, and other data as federally required or requested by MDHHS. Data will be used to assess the impact of the demonstration on access to services, quality and scope of services, and costs of providing a comprehensive array of behavioral health services. **(revised 4/1/2025)**

21.8.A. Cost Reporting [Change Made 4/1/2025]

CCBHCs must submit an annual cost report with supporting data to MDHHS. Cost reports and supporting data are based on CCBHC financial records and must follow the templates provided by the state. When reporting costs, the CCBHC must adhere to the 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. The CCBHC records must be detailed, orderly, complete, and available for review or audit. **(revised 4/1/2025)**

21.8.B. Quality Metric Reporting

CCBHCs are required to collect a core set of quality metrics as defined by CMS and MDHHS. Specifications for the required metrics are defined per federal guidance and detailed in the CCBHC Demonstration Handbook. CCBHCs must report data on individuals served by DCOs. It is the responsibility of the CCBHC to arrange for access to data required for reporting purposes.

SECTION 22 – MICHICANS

The Child and Adolescent Needs and Strengths (CANS) is a comprehensive information integration tool designed to summarize and organize information gathered from multiple sources and assessments. MDHHS utilizes a Michigan-specific version of the tool known as the MichiCANS. MDHHS requires Prepaid Inpatient Health Plans (PIHPs), Community Mental Health Services Programs (CMHSPs), and Certified Community Behavioral Health Clinics (CCBHCs) to use the MichiCANS to support potential eligibility for services, assist with initial determination of needs and strengths, and provide information for appropriate referrals for behavioral health services.

22.1 GENERAL DESCRIPTION

The MichiCANS Screener is the tool required at the point of access for all infants, toddlers, children, youth, and young adults ages birth through 20 years (day prior to 21). The results of the MichiCANS Screener will provide one of the following recommendations for level of need:

- Crisis Continuum of Care Services Need,
- Severe/Serious Level of Need, or
- Mild/Moderate Level of Need

Depending on the results of the MichiCANS Screener, the MichiCANS Comprehensive will be used at initial intake, annually thereafter, and at time of exit for infants, toddlers, young children, youth, and young adults ages birth through 20 years to guide treatment service planning. In addition, relevant sections of the MichiCANS Comprehensive will be updated when there is a significant change in life circumstances and/or a behavioral health event. The MichiCANS Comprehensive will be used to provide recommendations for eligibility for the Michigan Intensive Child and Adolescent Services (MICAS), which include Home-Based Services, Intensive Crisis Stabilization Services, Respite Services, Intensive Care Coordination with Wraparound, Youth Peer Support Services and Parent Support Partners.

PIHPs are required to use the Devereux Early Childhood Assessment at intake and during treatment planning, based on the results of the MichiCANS Screener, for infants, toddlers, and children ages one month up to age six who have (1) a Serious Emotional Disturbance (SED) or (2) SED and Intellectual/Developmental Disabilities (IDD). The results of the MichiCANS Comprehensive will also be used to identify areas of strengths and needs which will be used to assist with the planning process.

22.2 ELIGIBILITY FOR SPECIALTY BEHAVIORAL HEALTH SERVICES

The MichiCANS Screener is the tool required at the point of access for all infants, toddlers, children, youth, and young adults ages birth through 20 years (day prior to 21).

22.2.A. ELIGIBILITY CRITERIA AGES BIRTH THROUGH 5

The following MichiCANS Screener Decision Support Model criteria will be used to determine eligibility for Specialty Behavioral Health Services for children ages birth through 5 years (day prior to 6):

22.2.A.1. Level 1 – Mild/Moderate Level of Need (Referral to Appropriate Services)

A youth will be classified as 'MILD/MODERATE LEVEL OF NEED' if they meet Criterion 1.1 OR Criterion 1.2 OR Criterion 1.3 OR Criterion 1.4 OR Criterion 1.5.

Treatment Needs/Eligibility	
Criterion 1.1	A rating of '1', '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum Disorder
Criterion 1.2	A rating of '1', '2' or '3' on any of the Challenges items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Adjustment to Trauma ▪ Regulatory ▪ Atypical Behaviors ▪ Sleep (12+ months) ▪ Aggression
Criterion 1.3	A rating of '1', '2' or '3' on any of the Functioning items: ▪ Family Functioning ▪ Social & Emotional Functioning ▪ Early Care and Education ▪ Medical/Physical ▪ Motor (Fine/Gross) ▪ Sensory Responsiveness ▪ Restricted Interests
Criterion 1.4	A rating of '1', '2' or '3' on any of the Risk Factors & Behaviors items: ▪ Substance Exposure In Utero ▪ Environmental Toxin Exposure ▪ Prenatal Care ▪ Labor and Delivery ▪ Birth Weight ▪ Failure to Thrive ▪ Exploited ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting

Criterion 1.5	A rating of '1', '2' or '3' on any of the Caregiver items: ▪ Adjustment to Trauma Experiences ▪ Caregiver Capacity ▪ Supervision ▪ Knowledge

22.2.A.2. LEVEL 2 – SEVERE/SERIOUS LEVEL OF NEED (IF INITIAL, MOVE TO INITIAL ASSESSMENT)

Note: If a youth is identified as having a Severe/Serious Level of Need, the youth should be referred for an intake appointment through the PIHP.

A youth will be classified as 'SEVERE/SERIOUS LEVEL OF NEED' if they meet Criterion 2.1 OR Criterion 2.2) and (Criterion 2.3 OR Criterion 2.4 OR Criterion 2.5).

Treatment Needs/Eligibility	
Criterion 2.1	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum Disorder
Criterion 2.2	A rating of '2' or '3' on any of the Challenges items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Adjustment to Trauma ▪ Regulatory ▪ Atypical Behaviors ▪ Aggression

Complexity	
Criterion 2.3	A rating of '2' or '3' on any of the following items: ▪ Family Functioning ▪ Social & Emotional Functioning ▪ Early Care and Education ▪ Sleep (12+ months)

Criterion 2.4	A rating of '2' or '3' on any of the following items: ▪ Failure to Thrive ▪ Self-Harm (12+ months) ▪ Exploited ▪ Flight Risk/Bolting ▪ Cultural Stress (Caregiver Need)
Criterion 2.5	A rating of '2' or '3' on any of the Caregiver items: ▪ Adjustment to Trauma ▪ Mental Health ▪ Caregiver Capacity ▪ Supervision ▪ Involvement with Care ▪ Knowledge ▪ Safety

22.2.A.3. LEVEL 3 – CRISIS (MOVE TO CRISIS CONTINUUM OF CARE SERVICES)

A youth will be classified as 'CRISIS' if they meet Criterion 3.1.

Treatment Need/Eligibility	
Criterion 3.1	A rating of '3' on any of the following items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Regulatory ▪ Atypical Behaviors ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Exploited ▪ Safety (Caregiver Need)

22.2.B. ELIGIBILITY CRITERIA AGES 6 THROUGH 20

The following MichiCANS Screener Decision Support Model criteria will be used to determine eligibility for Specialty Behavioral Health Services for children ages 6 through 20 years (day prior to 21):

22.2.B.1. Level 1 – Mild/Moderate Level of Need – Referral to Appropriate Services

All children/youth are recommended for this level unless they are eligible for a higher level.

22.2.B.2. Level 2 – Severe/Serious Level of Need (If Initial, Move to Initial Assessment)

Note: If a youth is identified as having a Severe/Serious Level of Need, the youth should be referred for an intake appointment through the PIHP.

A youth will be classified as 'SEVERE/SERIOUS LEVEL OF NEED' if they meet (Criterion 2.1 OR Criterion 2.2) and (Criterion 2.3 OR Criterion 2.4).

Treatment Need/Eligibility	
Criterion 2.1	A rating of '2' or '3' on any of the Behavioral/Emotional Needs items: ▪ Psychosis ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use
Criterion 2.2	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum Disorder

Complexity	
Criterion 2.3	A rating of '2' or '3' on any of the following Life Functioning items or Caregiver Needs items: ▪ Family Functioning ▪ Living Situation ▪ Social Functioning ▪ Legal (age 11+) ▪ Medical/Physical

	▪ School ▪ Job Functioning (16+) ▪ Sleep ▪ Decision Making ▪ Caregiver Supervision
Criterion 2.4	A rating of '2' or '3' on any of the following Risk Behavior items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm ▪ Danger to Others ▪ Problematic Sexual Behavior ▪ Runaway ▪ Victimization/Exploitation

22.2.B.3. LEVEL 3 – CRISIS (MOVE TO CRISIS CONTINUUM OF CARE SERVICES)

A youth will be classified as 'CRISIS' if they meet Criterion 3.1 or Criterion 3.2.

Treatment Need/Eligibility	
Criterion 3.1	A rating of '3' on any of the following items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm ▪ Danger to Others ▪ Victimization/Exploitation ▪ Psychosis
Criterion 3.2	A rating of '3' on the Runaway item and at least one rating of '2' or '3' on any of the following items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm ▪ Danger to Others ▪ Victimization/Exploitation ▪ Psychosis

22.3 Home-Based Services

22.3.A. Eligibility Criteria

The criteria for home-based services are described below for children birth through age 5 and children aged 6 through age 20. These criteria do not preclude the provision of home-based services to an adult beneficiary prenatally or who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services when it is determined through a family-driven and youth-guided planning process that these services are necessary to meet the needs of the child and family. For continuing eligibility reviews during the transition to less intensive services, the child and family may be maintained in home-based services, even if they do not meet these criteria. Variation from the required criteria for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months.

22.3.A.1. Ages Prenatal/Birth through 5

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Home-Based Services for children ages birth through 5 years (day prior to 6).

A child will be recommended for 'Home-Based Services (Ages birth through 5)' if they meet Criterion A OR (Criterion A and Criterion B) AND Criterion C AND Criterion D.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the Challenges items: ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Aggression ▪ Regulatory ▪ Atypical Behaviors ▪ Sleep (12+ months) ▪ Adjustment to Trauma

Criterion B	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum

Complexity	
Criterion C	A rating of '2' or '3' on any of the following Risk Behavior items: ▪ Failure to Thrive ▪ Exploited ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Fire Setting (36+ months)
Criterion D	A rating of '2' or '3' on any of the following Life Functioning, Developmental Module, and Autism Spectrum Module items: ▪ Family Functioning ▪ Social & Emotional Functioning ▪ Early Care & Education Attendance ▪ Early Care & Education Behavior ▪ Early Care & Education Achievement ▪ Communication (Expressive/Receptive)+ ▪ Sensory Responsiveness** ▪ Receptive Communication** ▪ Expressive Language** ▪ Restricted Interests**

+Developmental Module item

**Autism Spectrum Module item

22.3.A.2. AGES 6 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Home-Based Services for children, youth, and young adults ages 6 through 20 years (day prior to 21).

A youth will be recommended for 'Home-Based Services (Ages 6 through 20)' if they meet Criterion A OR (Criterion A and Criterion B) AND Criterion C AND Criterion D.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use
Criterion B	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum

Complexity	
Criterion C	A rating of '2' or '3' on any of the following Risk Behavior items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm (Recklessness) ▪ Victimization/Exploitation ▪ Intentional Misbehavior ▪ Danger to Others ▪ Runaway
Criterion D	A rating of '2' or '3' on any of the following Life Functioning items: ▪ Family Functioning ▪ Living Situation ▪ Social Functioning ▪ Sexual Development ▪ School Attendance ▪ School Behavior

22.4 Respite Care

22.4 A. Eligibility Criteria

MichiCANS will be used to support eligibility determinations for respite for children and youth enrolled in the 1915(i), Children's Waiver Program, Waiver Program for Children with Serious Emotional Disturbances, and Habilitation Supports Waiver.

22.4.A.1. Ages Birth through 5

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Respite Care for beneficiaries ages birth through 5 years (day prior to 6).

A child will be recommended for 'Respite Care (Ages birth through 5)' if they meet (Criterion A OR Criterion B) AND (Criterion C OR Criterion D OR Criterion E).

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the following Challenges items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Aggression ▪ Regulatory ▪ Atypical Behaviors ▪ Sleep (12+ months) ▪ Adjustment to Trauma

Complexity	
Criterion C	A rating of '1', '2' or '3' on any of the following Life Functioning, Developmental Module, and Autism Spectrum Module items: ▪ Family Functioning ▪ Social & Emotional Functioning ▪ Early Care & Education Attendance ▪ Early Care & Education Behavior

	▪ Early Care & Education Achievement ▪ Communication (Expressive/Receptive) + ▪ Sensory Responsiveness** ▪ Receptive Communication** ▪ Expressive Language** ▪ Restricted Interests**
Criterion D	A rating of '1', '2' or '3' on any of the following Risk Behavior items: ▪ Failure to Thrive ▪ Exploited ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Fire Setting (36+ months)
Criterion E	At least one rating of '3' or two or more ratings of '2' on any of the following Caregiver Resources and Needs items. ▪ Supervision ▪ Involvement with Care ▪ Organization ▪ Medical/Physical ▪ Mental Health ▪ Substance Use ▪ Developmental ▪ Marital/Partner Violence in the Home ▪ Legal Involvement

+Developmental Module item

**Autism Spectrum Module item

22.4.A.2. AGES 6 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Respite Care for beneficiaries ages 6 through 20 years (day before 21).

A youth will be recommended for 'Respite Care (Ages 6 through 20)' if they meet (Criterion A OR Criterion B) AND (Criterion C OR Criterion D OR Criterion E).

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the following Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use

Complexity	
Criterion C	At least one rating of '3', or two or more ratings of '2' on any of the following Life Functioning items or item groups*: ▪ Family* ➢ Family Functioning, or ➢ Living Situation ▪ Social Functioning ▪ Recreational ▪ Legal (age 11+) ▪ Sexual Development ▪ Sleep ▪ School Attendance ▪ Decision Making ▪ Medical/Physical

Criterion D	A rating of '1', '2' or '3' on any of the following Risk Behavior items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm (Recklessness) ▪ Victimization/Exploitation ▪ Intentional Misbehavior ▪ Danger to Others ▪ Runaway ▪ Delinquent Behavior ▪ Fire Setting
Criterion E	At least one rating of '3', or two or more ratings of '2' on any of the following Caregiver Resources and Needs items: ▪ Supervision ▪ Involvement with Care ▪ Organization ▪ Medical/Physical ▪ Mental Health ▪ Substance Abuse ▪ Developmental ▪ Marital/Partner Violence in the Home ▪ Legal Involvement

*For the Family Item Group, choose the highest rating of the grouped items and count that rating once for the item criteria towards meeting Criterion C.

22.5 Intensive Care Coordination with Wraparound (ICCW)

22.5.A. Eligibility Criteria

The following criteria will help support eligibility for ICCW.

Children, youth, or young adults ages birth through 20 years (day prior to 21) are eligible for ICCW if they meet the following criteria:

- Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability
- Presenting with complex behavioral needs; and
- Have an identified community

AND two or more of the following criteria:

- Currently in or at risk of out-of-home placement.
- Involved in two or more child, youth, or young adult-serving systems, including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other school support services).
- Has received other case management or case management-like services, and higher intensity is required to meet needs.
- Lack of an identified support system.
- Presenting with complex medical needs and stabilization has not been reached.
- Has a functional impairment related to school activities, attendance, or performance. This includes, but is not limited to, experiencing multiple suspensions and/or expulsions.
- Displays significant physical and/or emotional distress after experiencing a traumatic event. Traumatic events may include, but are not limited to, natural disasters, acts of violence, abuse, neglect.

22.5.A.1. AGES BIRTH THROUGH 5

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for ICCW for beneficiaries ages birth through 5 years (day prior to 6).

A child will be recommended for 'ICCW (Ages birth through 5)' if they meet (Criterion A OR Criterion B) AND (Criterion C OR Criterion D) and Criterion E.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the following Challenges items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Aggression ▪ Regulatory ▪ Atypical Behaviors ▪ Sleep (12+ months) ▪ Adjustment to Trauma

Complexity	
Criterion C	At least one rating of '3' or two or more ratings of '2' on any of the following Life Functioning, Developmental Module, and Autism Spectrum Module items or item groups*. ▪ Family Functioning ▪ Social & Emotional Functioning ▪ Sensory Responsiveness** ▪ Restricted Interests** ▪ Communication* -- either ➢ Communication (Expressive/Receptive) +, ➢ Receptive Communication**, or ➢ Expressive Language** ▪ Early Care & Education* – either ➢ Attendance, or ➢ Behavior, or ➢ Achievement
Criterion D	At least one rating of '3', or two or more ratings of '2' on any of the following Risk Behavior items: ▪ Failure to Thrive ▪ Exploited ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Fire Setting (36+ months)
Criterion E	At least one rating of '3' or two or more ratings of '2' on any of the following Caregiver Resources and Needs items. ▪ Supervision ▪ Involvement with Care ▪ Knowledge ▪ Organization ▪ Social Resources ▪ Financial Resources ▪ Residential Stability ▪ Medical/Physical ▪ Mental Health ▪ Substance Use

	▪ Developmental ▪ Safety ▪ Marital/Partner Violence in the Home ▪ Legal Involvement

+Developmental Module item

**Autism Spectrum Module item

*For the 'Communication Item Group' and the 'Early Care and Education Item Group', choose the highest rating of the grouped items and count that rating once for the group. For example, if all of the 'Early Care and Education' items (Attendance, Behavior, and Achievement) are rated '2', one rating of '2' is counted for the item criteria towards meeting Criterion C.

22.5.A.2. AGES 6 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for ICCW for beneficiaries ages 6 through 20 years (day prior to 21).

A youth will be recommended for 'ICCW (Ages 6 through 20)' if they meet (Criterion A OR Criterion B) AND (Criterion C OR Criterion D) and Criterion E.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	At least one rating of '3', or two or more ratings of '2' on any of the following Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use

Complexity	
Criterion C	At least one rating of '3', or two or more ratings of '2' on any of the following Life Functioning items or item groups*: ▪ Family* ➢ Family Functioning, or ➢ Living Situation ▪ Social Functioning ▪ Recreational ▪ Legal (age 11+) ▪ Sexual Development ▪ Sleep ▪ School Attendance ▪ School Behavior ▪ School Achievement ▪ Decision Making ▪ Medical/Physical
Criterion D	At least one rating of '3', or two or more ratings of '2' on any of the following Risk Behaviors items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm (Recklessness) ▪ Victimization/Exploitation ▪ Intentional Misbehavior ▪ Danger to Others ▪ Runaway ▪ Delinquent Behavior ▪ Fire Setting
Criterion E	At least one rating of '3', or two or more ratings of '2' on any of the following Caregiver Resources and Needs items: ▪ Supervision ▪ Involvement with Care ▪ Knowledge ▪ Organization ▪ Social Resources ▪ Financial Resources ▪ Residential Stability

	▪ Medical/Physical ▪ Mental Health ▪ Substance Use ▪ Developmental ▪ Safety ▪ Marital/Partner Violence in the Home ▪ Legal Involvement

*For the 'Family Item Group', choose the highest rating of the grouped items and count that rating once for the item criteria towards meeting Criterion C.

22.6 Intensive Crisis Stabilization Services for Children

22.6.A. Eligibility Criteria

These services are for children or youth ages birth through 20 years (day prior to 21) with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of Intensive Crisis Stabilization Services (ICSS) in the home or community as defined in this section.

The child and family define the crisis, and eligibility for receiving children's ICSS will be based on the child and family requesting this service. The MichiCANS DSM may identify beneficiaries who may benefit from crisis services and, if this is a recommendation from the MichiCANS, the treatment team should incorporate this into the family-driven youth-guided planning process.

22.6.A.1. Ages Birth through 5

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for ICSS for beneficiaries ages birth through 5 years (day prior to 6).

A child will be recommended for 'ICSS (ages birth through 5)' if they meet (Criterion A OR Criterion B) AND Criterion C AND Criterion D.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the Challenges items: ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety

	▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Regulatory ▪ Adjustment to Trauma

Complexity	
Criterion C	At least one rating of '3', or two or more ratings of '2' on any of the following items: ▪ Aggression ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Fire Setting (36+ months)
Criterion D	A rating of '1', '2', or '3' on the Caregiver Resources and Needs item: ▪ Supervision

22.6.A.2. AGES 6 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for ICSS for beneficiaries ages 6 through 20 years (day prior to 21).

A youth will be recommended for 'ICSS (ages 6 through 20)' if they meet (Criterion A OR Criterion B) AND (Criterion C OR Criterion D) and Criterion E.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use

Complexity	
Criterion C	A rating of '3' on any of the following Risk Behavior items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm (Recklessness) ▪ Danger to Others ▪ Runaway ▪ Fire Setting
Criterion D	Two or more ratings of '2' or '3' on any of the following Risk Behavior items: ▪ Suicide Risk ▪ Non-Suicidal Self-Injurious Behavior ▪ Other Self-Harm (Recklessness) ▪ Victimization/Exploitation ▪ Intentional Misbehavior ▪ Danger to Others ▪ Runaway ▪ Delinquent Behavior ▪ Fire Setting
Criterion E	A rating of '2' or '3' on the Caregiver Resources and Needs item: ▪ Supervision

22.7 YOUTH PEER SUPPORT SERVICES

22.7.A. ELIGIBILITY CRITERIA

Youth Peer Support Services is a peer-delivered service for youth and young adults who are 11 to 26 years of age. It is designed to support youth and young adults with a serious emotional disturbance/serious mental illness (SED/SMI) through shared activities and interventions in the form of nonjudgmental support, connection through lived experience and supporting self-advocacy.

22.7.A.1. AGES 11 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Youth Peer Support for beneficiaries 11 through 20 years.

A youth will be recommended Youth Peer Support for beneficiaries 11 through 20 years if they meet Criterion A AND Criterion B.

Treatment Need/Eligibility	
Criterion A	▪ Youth is at least 11 years old.
Criterion B	A rating of '2' or '3' on any of the Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use

22.8 Parent Support Partners

22.8.A. Eligibility Criteria

Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual and developmental disabilities as part of the treatment process to be empowered, confident, and have skills that will enable them to assist their child to improve in functioning.

22.8.A.1. Ages Birth through 5

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Parent Support Partners for beneficiaries ages birth through 5 years (day prior to 6).

A child will be recommended Parent Support Partner for beneficiaries (birth through 5 years of age) if they meet Criterion A OR Criterion B OR Criterion C.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following Life Functioning or Challenges items: ▪ Developmental/Intellectual ▪ Autism Spectrum ▪ Impulsivity/Hyperactivity (36+ months) ▪ Depression ▪ Anxiety ▪ Oppositional Behavior (36+ months) ▪ Attachment Difficulties ▪ Regulatory ▪ Atypical Behaviors ▪ Adjustment to Trauma

Criterion B	A rating of '2' or '3' on any of the following Challenges or Risk Behaviors items: ▪ Aggression ▪ Exploited ▪ Self-Harm (12+ months) ▪ Flight Risk/Bolting ▪ Fire Setting (36+ months)
Criterion C	At least one rating of '3', or two or more ratings of '2' on any of the following items: ▪ Family Functioning ▪ Social and Emotional Functioning ▪ Sleep (12+ months) ▪ Early Care & Education Attendance ▪ Early Care & Education Behavior ▪ Early Care & Education Achievement

22.8.A.2. AGES 6 THROUGH 20

The following MichiCANS Comprehensive Decision Support Model criteria will be used to determine eligibility for Parent Support Partners for beneficiaries ages 6 through 20 years (day prior to 21).

A youth will be recommended for Parent Support Partners (ages 6 through 20) if they meet Criterion A OR Criterion B.

Treatment Need/Eligibility	
Criterion A	A rating of '2' or '3' on any of the following items: ▪ Developmental/Intellectual ▪ Autism Spectrum
Criterion B	A rating of '2' or '3' on any of the Behavioral/Emotional Needs items: ▪ Psychosis (Thought Disorder) ▪ Impulsivity/Hyperactivity ▪ Depression ▪ Anxiety ▪ Oppositional Behavior ▪ Conduct (Antisocial Behavior) ▪ Attachment Difficulties ▪ Anger Control ▪ Eating Disturbance ▪ Adjustment to Trauma ▪ Substance Use

CHILDREN'S WAIVER COMMUNITY LIVING SUPPORT SERVICES APPENDIX

SECTION 1 - CHILDREN WITH CHALLENGING BEHAVIORS

1.1 PURPOSE

This Section is to help the CMHSP determine whether the challenging behavioral needs of the child support hourly care and other support services, and to determine the appropriate range of hourly care that can be authorized under the Community Living Support (CLS) waiver service. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

The amount of CLS services (i.e., the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified;
- Frequency, intensity, and duration of identified behaviors;
- How recently serious behaviors occurred;
- Actual specific effects of the behavior on persons in family and property;
- Level of family intervention required to prevent behavioral episodes;
- Extent to which family must alter normal routine to address behavioral needs of the child;
- Prognosis for change in the child's behavior;
- Whether or not child functions more effectively in any current setting than in other settings; and
- Age, size, and mobility of child.

1.2 CATEGORIES OF CARE

1.2.A. CATEGORY IV

Qualifications	Demonstrates mild level behaviors that may interfere with the daily routine of the family.
Definitions	**Mild Behavior:** Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.

1.2.B. CATEGORY III

Qualifications	Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.
Definitions	**Pattern of Behavior:** In addition to a single serious episode in the last year, significant daily behaviors are documented. **Medium Behavior:** Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood. **Occasional Property Destruction:** Property destruction that occurs with a frequency not greater than one time per week.

1.2.C. CATEGORY II

Qualifications	Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention or emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.
Definitions	**Moderate Behavior:** Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.

1.2.D. CATEGORY I

Qualifications	Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.
Definitions	**Severe Behavior:** Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.

SECTION 2 – MEDICALLY AND PHYSICALLY COMPLEX CHILDREN

2.1 PURPOSE

The purpose of this Section is to help the CMHSP determine whether CLS services are medically necessary. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

2.1.A. CATEGORY IV

Qualifications	A medical condition and requires significant levels of daily assistance or guidance with activities of daily living (ADLs). In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.
Examples	Includes levels of support that would exceed those expected for a person of the child's age in the areas of: ▪ Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring); ▪ Assistance and/or guidance with physical transfer (e.g. bed to chair); ▪ Assistance and/or guidance with therapeutic positioning and physical therapy; or ▪ The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver.

2.1.B. CATEGORY III

Qualifications	A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status, and delayed interventions are not associated with imminent risk to health status.
Examples	Includes a combination of interventions such as: ▪ G-tube feedings with no oral suctioning needs; ▪ PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter; ▪ Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions); ▪ Catheterization fewer than five times per day; ▪ Routine chest physiotherapy four or more times per day; ▪ Ostomy care; ▪ Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning;

	▪ Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours; or ▪ Documented evidence that positioning causes apnea and cyanosis, and that positioning is limited to positions with the body in less than a 45 degree angle to horizontal plane.

2.1.C. CATEGORY II AND CATEGORY I

Services for Category II and Category I children are covered under the Medicaid State Plan private duty nursing (PDN) benefit. Refer to the Private Duty Nursing Chapter of this manual for PDN coverage criteria.

SECTION 3 – COVERAGE DECISIONS

3.1 DECISION RESPONSIBILITY

The MDHHS Children's Waiver Review Team will continue to review all plans of service and current assessments, and prior authorize waiver services, for those children who:

- Qualify for Category of Care I; or
- Have been approved to receive additional CLS hours under the exception process.

The responsible CMHSP, following the Children's Waiver Decision Guide in the following subsection, will review and prior authorize waiver services for those Children's Waiver beneficiaries who are determined to qualify for Categories II, III, or IV.

3.2 DECISION GUIDE

The determination of the amount of hourly care should result from a person-centered planning/family-centered practice process that considers both the child's and family's needs. The Children's Waiver Decision Guide Table below assists in identifying the range of hours provided for children based on their category of care and the family's resources to provide that care. It is expected that hourly care services will be provided within the range for which the child qualifies. Within the four Categories of Care are five sections that apply to the child's family status. In determining the total number of hours, it is acceptable to use the highest range within the appropriate section of the eligible category. If the child is receiving Home Help services, those hours must be considered as part of the total hours allowable. For example, a child determined to have Category III level of care needs is eligible for a maximum of six hours a day while in school. If that child receives two hours per day of Home Help, CWP could then provide a maximum of four hours of CLS staffing per day. The range of hours identified in the guide is an average daily amount that is provided seven days a week, based on a monthly total authorization.

If the child is attending school an average of 25 hours per week, the Section VI maximum would apply unless the maximum exceeds the range qualified for in Sections I-V. In that case, the maximum range in Sections I-V would apply. The Section VI maximum would not be required during school breaks, such as Christmas, Easter, and summer vacations, or if the child is out of school due to illness for 5 or more consecutive days.

CHILDREN'S WAIVER DECISION GUIDE TABLE				
ADDITIONAL FAMILY RESOURCES	**DOCUMENTED CATEGORY OF NEED FOR HOURLY CARE AUTHORIZATION**			
	CATEGORY IV	**CATEGORY III**	**CATEGORY II**	**CATEGORY I**
Section I – Number of Caregivers				
1. Two or more caregivers live in home; both work F/T	4 - 8	6 - 10	8 - 12	12 - 16
2. Two adult caregivers; one works F/T	2 - 8	2 - 8	4 - 10	10 - 16
3. Two adult caregivers; neither is employed	2 - 4	2 - 6	4 - 8	8 - 12
4. One adult caregiver lives in home and works F/T	4 - 8	4 - 10	8 - 12	12 - 16
5. One adult caregiver; does not work F/T	2 - 6	2 - 8	8 - 10	10 - 14
Section II – Health Status of Caregivers				
1. Significant health issues	6 - 8	6 - 10	10 - 14	12 - 16
2. Some health issues	4 - 6	4 - 8	8 - 12	10 - 12
Section III – Additional Dependent Children				
1. Applicant has one or more siblings age 5 or older	2 - 4	2 - 6	4 - 8	8 - 12
2. Applicant has one or more siblings under age 5	4 - 6	4 - 8	6 - 8	8 - 12
Section IV – Additional Children with Special Needs				
1. Applicant has one or more siblings with nursing needs	4 - 8	6 - 8	4 - 8	8 - 12
2. Applicant has one or more siblings with non-nursing special needs	2 - 4	2 - 6	N/A	N/A
Section V – Night Interventions				
1. Requires 2 or fewer interventions at night or total time less than one hour	2 - 4	2 - 6	4 - 8	8 - 12
2. Requires 3 or more interventions requiring one hour or more to complete	4 - 8	6 - 8	6 - 10	8 - 12
Section VI – School				
1. Child attends school an average of 25 hours per week	6 max	6 max	8 max	12 max

3.3 Decision Guide Table Definitions

The definitions used in each section of the Decision Guide Table are as follows:

SECTION	DEFINITIONS
I – Number of Caregivers	Caregiver is defined as a legally responsible adult(s) living in the home or adult(s) who is not legally responsible but chooses to participate in providing care for the child. Full-Time (F/T) is defined as a person who works 30 or more hours per week for wages, or a person who attends school 30 or more hours per week.
II – Health Status of Caregivers	Significant health concerns of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition. Some health concerns of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month.

SECTION	DEFINITIONS
III - Additional Dependent Children	This section applies when the child has one or more siblings or related individuals under age 18 who reside in the home full-time and the caregiver is not paid for providing care.
IV - Additional Children With Special Needs	Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports. Siblings with nursing needs are children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (refer to the Behavioral Health 1915(i) Home and Community-Based Services State Plan Amendment section of this chapter), whether or not those children are developmentally disabled. Siblings without skilled nursing needs are children with needs as identified in Category of Care I-IV definitions.
V – Night Interventions	If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies. If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V-2 applies.
VI – School	Average hours of school should be used to determine the appropriate range of hours. Include transportation time if provided by the school. The number of hours of school attendance is based on the school year that applies to the child's educational classification. Variations in hours may be seen for children without a summer program. This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program. The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.

3.4 Exception Process

The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise. When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.

Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by MDHHS to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family-centered practice team recommendation, and CMHSP administrative concurrence.

The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception and a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/IID rules, and any enhancements must be essential to

maintain the child within their home. Consideration for an exception will be limited to situations outside the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g., an acute illness or injury);
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;
- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e., previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;
- Natural supports are unable to provide the requisite level of care (e.g., only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDHHS can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to MDHHS within 10 days; or
- In a non-emergency situation, the CMHSP provides MDHHS with written documentation of the specific rationale to support the exception (i.e., physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDHHS will occur within 10 working days.

When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDHHS may request a meeting in order to clarify and reconsider the basis for the exception.

MDHHS has the option to request a home visit to meet the child when it is necessary for an effective decision.

3.5 Appeal Process

The child and family have the right, under the Michigan Mental Health Code, to appeal a negative coverage decision to the director of the CMHSP. The child and family may also request a recipient's rights investigation through their CMHSP.

The CMS approval of the Children's Waiver requires the availability of a fair hearing for any Medicaid-eligible child enrolled in the Children's Waiver Program when that child is subject to a negative action. A negative action results when a Medicaid-covered service or benefit is taken away, reduced, or denied to a Medicaid beneficiary. The Medicaid beneficiary must be notified of the negative action in writing. The negative action notice must indicate:

- The beneficiary's right to appeal through the MDHHS administrative hearing process;
- The beneficiary has 90 days to submit an appeal; and
- Where to send the appeal.

The MDHHS appeal process may occur simultaneously with a recipient's rights or CMHSP administrative appeal process. Individuals and their families are encouraged to resolve disputes regarding waiver services at the local CMHSP level.

The CMHSP is financially responsible for any services that may be approved as a result of the judgment from the administration appeal process.

CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES HOME AND COMMUNITY-BASED SERVICES WAIVER APPENDIX

SECTION 1 – GENERAL INFORMATION

The Children With Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW) provides services that are enhancements or additions to Medicaid State Plan coverage for beneficiaries up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDHHS operates the SEDW through contracts with the PIHPs. The SEDW is a managed care program administered by the PIHPs in partnership with CMHSPs and other community agencies.

1.1 KEY PROVISIONS

The SEDW enables Medicaid to fund necessary home and community-based services for beneficiaries up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. The PIHP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the PIHP. The PIHP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the beneficiary and their family and friends, and other professional members of the planning team work cooperatively to identify the beneficiary's needs and to secure the necessary services. All services and supports must be included in an IPOS.

A SEDW beneficiary must receive at least one SED waiver service, in addition to Wraparound, per month in order to retain eligibility.

1.2 ELIGIBILITY

To be eligible for this waiver, the beneficiary must meet all the following criteria.

- Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR
- Reside with a legal guardian; OR
- Reside in a foster home with a permanency plan; OR
- Be age 18, 19 or 20 and live independently with supports; AND
- Meet current MDHHS criteria for the State psychiatric hospital for children or is at risk of hospitalization without waiver services; AND
- Meet Medicaid eligibility criteria and become a Medicaid beneficiary; AND
- Demonstrate serious functional limitations that impair their ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®), the Preschool and Early Childhood Functional Assessment Scale (PECFAS®), or the Devereux Early Childhood Assessment (DECA) Clinical Version scales:

- CAFAS® score of 90 or greater for beneficiaries ages 7 to 12; OR
- CAFAS® score of 120 or greater for beneficiaries ages 13 to 18; OR
- For beneficiaries ages 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; OR
- For beneficiaries ages 2 to 4, scores in the concern range across DECA Clinical Version scales:
    - Protective factor scales (initiative, self-control, and attachment) that are in the Concern Range with a Total Protective Factor T-score of 40 or below; and/or
    - Elevated scores on one or more of the behavioral concerns 32 scales (attention problems, aggression, withdrawal/depression, emotional control problems) with a T-score of 60 or above; AND

- Be under the age of 18 when approved for the waiver. If a beneficiary on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, they can remain on the waiver up to their 21st birthday.

1.3 Coverage Area

Waiver services are limited to eligible beneficiaries (up to the federally-approved maximums) living in the state of Michigan. PIHPs assure CMHSPs:

- Demonstrated strong collaboration with essential community partners; and
- Have the capacity to provide intensive community-based services at a level sufficient to meet the needs of waiver recipients.

SECTION 2 – COVERED WAIVER SERVICES [CHANGE MADE 4/1/2025]

Each beneficiary must have a comprehensive Wraparound Plan and IPOS that specify the services and supports that the beneficiary and family will receive. The Wraparound Plan is to be developed through the Wraparound Planning Process. Each beneficiary must have a Wraparound Facilitator who is responsible to assist the beneficiary/family in identifying, planning and organizing the Child and Family Team, developing the Wraparound Plan, and coordinating services and supports. (Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual for additional information.) **(revised per bulletin MMP 24-41)**

In addition to Medicaid state plan services, beneficiaries enrolled in the SEDW may receive any of the following Serious Emotional Disturbances Waiver (SEDW) services as identified in the Wraparound Plan and IPOS.

2.1 CHILD THERAPEUTIC FOSTER CARE

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,
- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior treatment skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving their social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of their family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

In addition to being licensed, all CTFC programs under this waiver are to be certified by MDHHS to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.

2.2 COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, thus facilitating a beneficiary's achievement of their goals of community inclusion and remaining in their home. The supports may be provided in the beneficiary's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

CLS provides assistance to the family in the care of their child while facilitating the child's independence and integration into the community. The supports, as identified in the Wraparound Plan and IPOS, are provided in the beneficiary's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary enabling the beneficiary to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

CLS includes:

- Assistance with skill development related to:
  - Activities of daily living (such as personal hygiene)
  - Household chores
  - Socialization
  - Improving communication and relationship-building skills
  - Participation in leisure and community activities
- Staff assistance, support and/or training with such activities as:
  - Improving the beneficiary's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors
  - Non-medical care (i.e., not requiring nurse or physician intervention)
  - Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence
  - Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.)
  - Assisting the family in relating to and caring for the beneficiary
  - Attendance at medical appointments
  - Acquiring or procuring goods other than those listed as shopping and non-medical services.
- Reminding, observing, rewarding and monitoring of pro-social behaviors.
- Medication administration.
- Staff assistance with preserving the health and safety of the beneficiary in order that the beneficiary may reside or be supported in the most integrated, independent community setting.

The maximum CLS allocation is 744 units (186 hours) per month.

2.3 Family Home Care Training

Family Home Care Training provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver and may include a parent and/or siblings or the foster parent(s) for a beneficiary in Child Therapeutic Foster Care. This service is provided by a Master's level social worker, psychologist, or qualified mental health professional (QMHP), includes instruction about treatment interventions and support intervention plans specified in the IPOS, and includes updates as necessary to safely maintain the beneficiary at home.

Family Home Care Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a beneficiary with special needs and to help the beneficiary remain at home. All family training must be included in the beneficiary's IPOS and must be provided on a face-to-face basis and with the family present.

2.4 Family Support and Training

For Parent Support Partner Service, refer to the Family Support and Training subsection (Behavioral Health §1915(I) Home and Community-Based Services (HCBS) State Plan Amendment Supports and Services section) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.

2.5 Fiscal Intermediary Services

A fiscal intermediary is an independent legal entity that acts as the fiscal agent of the PIHP for the purpose of ensuring financial accountability for the funds authorized to purchase the services and supports identified in the beneficiary's IPOS. The fiscal intermediary receives the funds; makes payments authorized by the beneficiary's representative to providers of services and supports; and acts as an employer agent when the beneficiary's representative directly employs staff or other service providers.

Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary's parent or guardian, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Ensuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary and their representative to self-direct needed services and supports. These functions may include helping the beneficiary recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing) – as requested by the beneficiary's representative; contracting with or employing and directing providers of services; verification of provider qualifications (including reference and background checks); and assisting the beneficiary and their representative to understand billing and documentation requirements.

This waiver service is limited to beneficiaries who choose to self-direct services through Choice Voucher/Self Determination arrangements. The "unit" for this billable code is "per month" and can be billed once per month for beneficiaries using Choice Voucher/ Self Determination arrangements.

2.6 Home Care Training, Non-Family

This service is reimbursable for up to four sessions per day but no more than 12 sessions per 90 days (i.e., three calendar months). A session can be of varying lengths of time but should meet the needs of the plan of service (POS); a billable session must be at least 45 minutes.

This service provides coaching, training, supervision and monitoring of CLS staff by clinicians (i.e., licensed psychologist, Master's level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the beneficiary's POS, with focus on services designed to improve the beneficiary's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the beneficiary or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of their competency in the aspect of the POS on which training is conducted.

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations.

2.7 Overnight Health and Safety Support (OHSS) Services

NOTE: OHSS is not available for beneficiaries residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian.

The need for OHSS must be reviewed and established through the person-centered planning process with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety.

2.7.A. COVERAGE [CHANGES MADE 4/1/2025]

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period.

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the IPOS, encompassing both health and safety support services needed for the beneficiary to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.
- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow a beneficiary to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.
- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night.
- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).
- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.
- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.
- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a

medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.

- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.
- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
- OHSS is not available for a beneficiary who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.
- OHSS is not intended to supplant services, such as respite services, for the relief of the primary caregiver or legal guardian living in the same home. **(revised 4/1/2025)**
- OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. **(text added 4/1/2025)**
- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.

2.7.B. Coordination of Services and Care

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into this category of "round-the-clock" by the nature and institutional level of care required for Home and Community Based Services (HCBS) Waiver participants. OHSS is intended to supplement other HCBS (i.e., CLS, respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the other community support services to prevent issues of duplicative services. OHSS is complementary of the other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of a beneficiary overnight.

2.7.C. Provider Services

Providers have the responsibility for the health, welfare, and safety of the beneficiary overnight and must be awake to have the ability to intervene on behalf of the beneficiary. This assistance may take the form of observation and minor redirection of the beneficiary to perform tasks that will enable the beneficiary to maintain their overnight health and sleep safety.

Providers may perform minor redirection and/or prompting that are incidental to the care and supervision of the beneficiary over the course of the night such as:

- The ability to intervene on behalf of the beneficiary supervision of overnight activities, such as reinforcing independent living skills and minor redirection of their independent daily living tasks.
- Provide the level of supervision needed to ensure a beneficiary's safety, along with the actions required if a beneficiary's health or welfare are at risk.
- Safeguard the individualized supports needed overnight appropriate to the beneficiary's needs. Common issues, which include fire and evacuation ability, ability to respond independently to health needs during the night, and safety awareness.

2.8 Respite Care

Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. This service can be provided by a qualified provider under contract with the PIHP/CMHSP. A parent or guardian may not be considered a provider, nor be reimbursed for this service. The maximum respite allocation is 1,248 units (312 hours) per month.

Federal Financial Participation (FFP) may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations:

- Beneficiary's home or place of residence
- Home of a relative or family friend's home in the community
- Licensed Children's Camp
- Licensed Foster Family Home or Foster Family Group Home
- Licensed Children's Therapeutic Group Home

2.9 Therapeutic Activities

A therapeutic activity is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the POS. The POS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the POS. Providers are identified through the wraparound planning process and participate in the development of a POS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the POS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy. NOTE: The unit of service when billing G0176 for children/youth on the SEDW is per session, 45 minutes or more.

The training, coaching, supervision and monitoring activities provided under this service are specific to music, art, and recreation therapy and must be provided by providers with the qualifications listed below.

Recreation Therapy	Must be provided by a Certified Therapeutic Recreation Specialist credentialed by the National Council for Therapeutic Recreation Certification (NCTRC).
Music Therapy	Must be provided by a Music Therapist - Board Certified (MT-BC) or by a music therapist listed on the National Music Therapy Registry (NMTR).
Art Therapy	Must be provided by a Registered Art Therapist - Board Certified (ATR-BC).

2.10 Therapeutic Overnight Camp

Therapeutic Overnight Camp is a group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service. The maximum overnight camp allocation is $1,400 per session – three sessions per fiscal year.

Additional criteria:

- Camps are licensed by MDHHS;
- The beneficiary's IPOS includes Therapeutic Overnight Camp; and
- Camp staff is trained in working with beneficiaries with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp; and
- Additional costs for staff with specialized training with this population.

Coverage excludes:

- Room and board for the camp.

2.11 Wraparound Services [Change Made 4/1/2025]

(Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents subsection of the Covered Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.) **(revised per bulletin MMP 24-41)**

Wraparound services for beneficiaries is a highly individualized planning process facilitated by specialized Wraparound Facilitators. Due to the intense needs and level of risk of beneficiaries and their families served in the SEDW, all SEDW Wraparound providers must meet the following additional requirement:

- Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to beneficiaries and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators.

SECTION 3 – MEDICAID STATE PLAN SERVICES

In addition to SEDW services, beneficiaries served by the SEDW have access to Medicaid Mental Health State Plan services (e.g., psychotherapy, medication management, OT and PT evaluations, home based services). Services that can be billed to Medicaid are listed on the PIHP/CMHSP Encounter Reporting Healthcare Common Procedure Coding System (HCPCS) and Revenue Codes chart which is available on the MDHHS website. The code chart lists the CPT/HCPCS code, modifiers (when applicable), short description, Medicaid fee screen, and applicable quantity/timeframe parameters for each service. (Refer to the Directory Appendix for website information.)

Transportation is a Mental Health State Plan service. Parameters related to this service for SEDW enrollees are identified.

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so that a beneficiary may participate in a state plan, HSW, or additional/1915(i) State Plan Amendment (SPA) service at an approved day program site or in a clubhouse psychosocial rehabilitation program. Medicaid Health Plans (MHPs) are responsible for assuring enrollee transportation to Medicaid covered medical appointments. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs (except those noted above and in the HSW program – described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter).

For beneficiaries enrolled in the SEDW, transportation may be reimbursed when separately specified in the IPOS and provided in order to enable a beneficiary served by the SEDW to gain access to waiver and other community services, activities, and resources. The transportation benefit is limited to mileage reimbursement, and can be paid to hourly staff (e.g., respite and CLS) and clinical/professional staff providers. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the SEDW. The SEDW-enrolled beneficiary, legally responsible caregivers, and foster care providers cannot be reimbursed for mileage.

SECTION 4 – PROVIDER QUALIFICATIONS

4.1 RESPITE AND CLS

Individuals who provide respite and CLS must, in addition to the specific training, supervision and standards for each support/service, be:

- A responsible adult at least 18 years of age;
- Able to prevent transmission of communicable disease;
- Able to communicate expressively and receptively in order to follow IPOS requirements, and beneficiary-specific emergency procedures, and report on activities performed;
- In "good standing" with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty they would be performing, not an illegal alien);
- Able to perform basic first aid procedures; and
- Trained on the IPOS, as applicable.

4.2 WRAPAROUND FACILITATOR

Wraparound facilitators must:

- Complete MDHHS Wraparound training;
- Possess a bachelor's degree in any field;
- Have a criminal history screen, including state and local child protection agency registries; and
- Be supervised by an individual who meets criteria as a Child Mental Health Professional (CMHP) who has completed MDHHS required training.

4.3 CHILD THERAPEUTIC FOSTER CARE

Child Therapeutic Foster Care (CTFC) providers must be:

- Licensed as a Foster Care Provider (MCL 722.122);
- Enrolled by MDHHS as a CTFC provider; and
- Trained in the IPOS.

4.4 THERAPEUTIC OVERNIGHT CAMP

Therapeutic Overnight Camps must be licensed and certified by MDHHS. Staff must be trained in the IPOS.

NON-PHYSICIAN BEHAVIORAL HEALTH APPENDIX

SECTION 1 - GENERAL INFORMATION

This appendix applies to non-physician behavioral health providers, including psychologists, social workers, counselors, and marriage and family therapists, providing outpatient behavioral health services not included under the specialty services and supports benefit. Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement Chapters of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 2 – PROVIDER QUALIFICATIONS

Medicaid covers non-physician behavioral health services when performed by any of the following provider types:

- Licensed Psychologist (Doctoral Level)
- Licensed Social Worker (Master's level)
- Licensed Marriage and Family Therapist (Master's or Doctoral level)
- Licensed Professional Counselor (Master's or Doctoral level),
- Limited Licensed Psychologist (Master's or Doctoral Educational level) (LLPs) under the supervision of an enrolled, fully licensed psychologist (except as noted in Section 333.18223 of the Public Health Code).

These practitioners are required to be currently licensed by the Department of Licensing and Regulatory Affairs (LARA), enroll as Medicaid providers, and be uniquely identified on all claims. (Refer to the Billing & Reimbursement for Professionals Chapter for billing information.)

LLPs must enroll as Rendering/Servicing Only providers and associate themselves to at least one Billing Provider within CHAMPS. Associated Billing Providers may be either employers or organizations the LLP is contracted with to perform services (i.e., Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs]).

Non-physician behavioral health services may also be performed by any of the following provider types under the supervision of an enrolled, fully licensed provider of the same profession:

- Temporary Limited License Psychologist (Master's or Doctoral Level)
- Educational or Temporary Limited License Social Worker, Marriage and Family Therapist, or Professional Counselor
- Graduate of a board-approved health profession training program for psychology, social work, counseling, or marriage and family therapy (Master's or Doctoral Level) who has completed all requirements but has not obtained a limited or temporary educational license. Medicaid will cover services for a period of no longer than one year from the date the individual successfully completed their graduate coursework. The graduate's supervising provider must monitor and ensure compliance of this requirement.
- Student Intern. A student intern is an individual who is currently enrolled in a health profession training program for psychology, social work, counseling, or marriage and family therapy that has been approved by the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. Social work student interns must be pursuing a Master's degree in social work and be supervised by a Licensed Master's Social Worker in a manner that meets the requirements of a Council on Social Work Education (CSWE) accredited education program curriculum that prepares an individual for licensure.

Student interns, graduates and temporary or educational limited licensed providers are not eligible to enroll or be directly reimbursed by Medicaid. Services should be billed to Medicaid under the National Provider Identifier (NPI) of the supervising provider.

Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978) when required.

To comply with 42 CFR 431.110, licensed health professionals employed by a Tribal Health Program must be licensed in good standing in at least one state, but do not need to be licensed in the state where they are practicing. This Federal regulation supersedes any licensing requirements of individual states.

SECTION 3 – COVERED SERVICES

Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHP/CMHSP may receive outpatient behavioral health services directly through the Fee-for-Service (FFS) Medicaid program or Medicaid Health Plan. Non-physician behavioral health services performed by psychologists, social workers, counselors, and marriage and family therapists are covered when performed in a non-facility setting or outpatient hospital clinic and provided within their specific profession's scope of practice guidelines as defined by State law. Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable.

Services covered by the PIHPs/CMHSPs are available and reimbursed through the PIHP/CMHSP. Providers should refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information on these services.

3.1 PRIMARY CARE OFFICE-BASED SUBSTANCE USE TREATMENT (OBSUT)

Providers working in a primary care setting are permitted to seek fee for service (FFS) or Medicaid Health Plan reimbursement for substance use treatment services in an office-based setting. (Refer to the Primary Care Office-Based Substance Use Treatment (OBSUT) subsection in the Practitioner chapter for additional information regarding reimbursement provision.)

SECTION 4 – TELEMEDICINE

Behavioral health services may be delivered via telemedicine in accordance with current Medicaid policy. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in their health care profession in the state where the patient is located. Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

SECTION 5 – CLAIMS PROCESSING AND REIMBURSEMENT AMOUNTS

Information regarding claims processing is available in the Billing & Reimbursement for Professionals chapter of this manual.

Licensed Psychologist (Doctoral level), Licensed Social Worker (Master's level), Licensed Marriage and Family Therapist (Master's or Doctoral level), or Licensed Professional Counselor (Master's or Doctoral level) behavioral health professionals may receive direct reimbursement for Medicaid covered services.

Limited License Psychologists (LLPs) (Master's and Doctoral Educational level) are not eligible to be directly reimbursed by Medicaid and must associate themselves to at least one billing provider within CHAMPS. LLP services requiring supervision and billed on a professional claim form must include the NPI of the LLP in the Rendering Provider field and the NPI of the Medicaid enrolled supervising Licensed Psychologist in the Supervising Provider field.

All temporary limited licensees, educational limited licensees other than Doctoral Educational Limited License Psychologists, and student interns are not eligible to be directly reimbursed by Medicaid. Services should be billed to Medicaid under the NPI of the supervising provider. The supervising provider must be listed as the Rendering Provider on the claim.

Non-physician behavioral health payment rates are established by MDHHS as a fee screen for each procedure. Services performed by non-physician behavioral health providers are reimbursed at a percentage of the Medicaid practitioner fee schedule rate. Refer to the Medicaid Non-Physician Behavioral Health fee schedule or the Community Health Automated Medicaid Processing System (CHAMPS) Medicaid Rate and Reference tool for additional information. The fee schedule is reviewed and updated at least annually.

For beneficiaries enrolled in a MHP, the provider must contact the MHP for applicable claim completion instructions as these may vary from the FFS Medicaid program.

BRAIN INJURY SERVICES

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) is committed to providing high quality services and supports to individuals who have experienced a brain injury. Brain Injury Services (BIS) provides necessary services and supports to individuals with qualifying brain injuries who, but for the provision of these services, would otherwise be served in an institutional setting. The program provides critical brain injury-specific rehabilitation and support in the post-acute injury period with the goal of assisting the individual in becoming capable of living in the most independent setting.

1.1 BRAIN INJURY SERVICES SCOPE AND PURPOSE

BIS focuses on specialized rehabilitation and supportive services required upon release from an acute care setting following a moderate or severe brain injury. A brain injury does not include damage to the brain resulting from neurodegenerative disorders such as Alzheimer's disease or dementia. These services are for beneficiaries who can benefit from the advanced level of rehabilitative therapies and other services offered. BIS can be obtained in either a transitional residential or outpatient setting. All providers for BIS must have appropriate accreditation, certifications, or specialized training in serving individuals with brain injuries. These BIS providers are contracted with MDHHS to provide services covered in this chapter. Transitional Residential services are limited to six months for each brain injury.

1.2 BENEFICIARY ELIGIBILITY

To be eligible for BIS, an individual must meet the following criteria:

- Be Medicaid-eligible.
- Have a qualifying brain injury that occurred within 15 months of application to the BIS program. (Refer to the Beneficiaries with a Traumatic Brain Injury and the Beneficiaries with an Acquired Brain Injury subsections for additional information.)
- Be medically stable.
- Be able to participate in appropriate therapies as indicated:
  - For beneficiaries using Transitional Residential services, at least 15 hours per week upon approval for BIS. These beneficiaries may decrease the number of therapy hours based upon a beneficiary evaluation when nearing discharge if most of the treatment goals have been met and the discharge plan has been reevaluated and revised to ensure it remains appropriate for the beneficiary.
  - For beneficiaries receiving Outpatient services, at least nine (9) hours per week.
- Be determined appropriate for 60 to 90 days of BIS as supported by a Physical Medicine and Rehabilitation (PMR) physician's order.
  - For beneficiaries using Transitional Residential services, the order must specify that the physician expects significant progress within the next 90 days to allow for community-based discharge.
  - In the absence of a PMR physician's order, a psychological consultation conducted by a qualified professional that substantiates the beneficiary's ability to interact with the therapy treatment team and the ability to participate in the required therapy levels will be accepted.

1.2.A. Early and Periodic Screening, Diagnosis, and Treatment Age-Outs

Beneficiaries who otherwise qualify for BIS but are receiving similar services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will age-out of the EPSDT program before completing brain injury treatments and therapies may enroll in BIS upon their 21st birthday. Providers should collaborate in advance of the 21st birthday to ensure minimization of interrupted services for these beneficiaries.

1.2.B. Beneficiaries with a Traumatic Brain Injury

A traumatic brain injury (TBI) is defined as a blunt force trauma to the brain. The Centers for Disease Control and Prevention (CDC) defines a TBI as "caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain." Injuries such as gunshot wounds, falls or motor vehicle accidents involving injuries to the head are considered TBIs. Explosive blasts can also cause a TBI, particularly among those who serve in the United States (U.S.) military.

1.2.C. Beneficiaries with an Acquired Brain Injury

An acquired brain injury (ABI) is an injury to the brain that is not hereditary, congenital degenerative, or induced by birth trauma. ABIs occur after birth but are not caused by an external force and are non-traumatic. Examples of ABI include stroke, near drowning, substance abuse overdose, hypoxic or anoxic brain injury, tumors, neurotoxins, electric shock, or lightning strike.

1.2.D. Time Since Injury

Beneficiaries must have sustained the qualifying brain injury within 15 months of applying for BIS.

1.2.E. Functioning Level

Beneficiaries must demonstrate functioning at a Level 5 on the Rancho Los Amigos scale based on the most recent medical records available. Beneficiaries functioning at a lower level but steadily progressing may be considered for enrollment. MDHHS will make this exception based on a review of medical documentation submitted to MDHHS.

1.2.F. Enrollment in Medicaid Health Plans and Other Programs

A program participant cannot be simultaneously enrolled in both BIS and a Medicaid Health Plan (MHP), Program of All-Inclusive Care for the Elderly (PACE) program, MI Health Link, MI Choice or any other §1915(c) waiver program. It is not necessary to either delay BIS program enrollment or withhold BIS pending the disenrollment process. Disenrollment from other programs will be coordinated by the MDHHS Home and Community-Based Services (HCBS) Section. Special disenrollment or medical exception processes for BIS program enrollment are not allowed.

1.3 Beneficiary Discharges

All beneficiaries will develop a discharge plan as a part of their care plan. The discharge plan will be altered as necessary based upon the beneficiary's goals and outcomes. Beneficiaries who have met most of their goals will begin intensive discharge planning. These beneficiaries may require other home and community-based services (HCBS) programs upon conclusion of BIS. Intensive discharge planning will include planning for enrollment in the most appropriate program for the beneficiary based upon their choice and eligibility for other programs. Every effort will be made to ensure a smooth transition out of the BIS and into other Long-Term Services and Supports (LTSS) programs, as needed, without a lapse between BIS and other program enrollment. MDHHS allows 30 days to facilitate an appropriate discharge.

Discharge from BIS will be based upon the beneficiary meeting any of the following criteria:

- The beneficiary is not eligible for Michigan Medicaid;
- The beneficiary died;
- The beneficiary is not amenable to treatment;
- The beneficiary is non-compliant with program or facility rules;
- The beneficiary has been institutionalized in a hospital or nursing facility for more than 30 days;
- The beneficiary enrolled in a hospice program;
- The beneficiary moved out of the program service area;
- The beneficiary has not shown progress for at least 30 days while approved for BIS;
- The beneficiary chooses to end BIS;
- The beneficiary transferred to a different program or service and no longer requires BIS;
- The beneficiary no longer meets program criteria;
- The beneficiary refused to accept BIS;
- The beneficiary met program goals as established in their care plan; or
- The beneficiary has been enrolled in Transitional Residential services of BIS for six months and does not require or has refused Outpatient services.

SECTION 2 – REFERRAL AND ADMISSION PROCESS

Any knowledgeable person may make a referral for BIS. MDHHS recommends, but does not require, the current social worker or nurse assigned to the beneficiary to contact MDHHS for easier processing of the referral and to provide a brief report of the beneficiary. An individual, family member or friend may contact MDHHS if they want more information about the program or feel their friend or family member may qualify. MDHHS will provide the friend or family with information about the program, answer questions, and provide a list of contracted BIS providers. The potential applicant or family member will have to decide which provider meets their needs and is right for them. MDHHS will then work with the BIS providers to get the complete admission packet and determine if the individual is eligible for the program.

MDHHS will evaluate the application of each individual with a brain injury who applies for BIS using the criteria listed below. All applicants for BIS must meet each criterion at the time of application. MDHHS will not consider applicants who do not meet all criteria specified below for enrollment in the BIS.

2.1 IN-PERSON EVALUATION

Providers must conduct an in-person evaluation to determine whether the beneficiary meets provider admission criteria before making a referral. The provider may request a joint evaluation with MDHHS HCBS staff. MDHHS reserves the right to conduct an in-person assessment of the beneficiary.

When appropriate, the evaluation may occur through telecommunication technology (telemedicine). MDHHS requires a real-time interactive system at both the originating and distant sites, allowing instantaneous interaction between the patient and the health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary. Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. (Refer to the Telemedicine chapter of this manual for additional telemedicine requirements.)

2.2 MEDICAL RECORDS

Medical records from the acute or institutional care setting, hereafter referred to as "care setting," immediately prior to application for BIS must demonstrate all the following:

- The injury occurred no more than 15 months before the BIS application date or start of Brain Injury-specific services through the EPSDT program;
- The beneficiary is at least 21 years old;
- The beneficiary has been determined to have a significant functional or cognitive impairment as identified by a comprehensive assessment and must require long-term support services;
- The beneficiary must have functional or cognitive limitations that are a direct result of a brain injury as documented by a physician, neuropsychologist, or other qualified health professional;
- The beneficiary has potential to maintain skills learned at the setting such as coping mechanisms or other techniques to compensate for identified functional or cognitive deficits;
- The beneficiary does not require continuous 1:1 attention to remain free from harm within the care setting;

- The beneficiary is willing and able to participate in targeted brain injury therapies and work toward identified goals;
- The beneficiary exhibits behavior that does not pose significant harm to self or others; and
- The beneficiary has not used illegal substances or abused legal substances in the care setting or at home after discharge from the last treatment facility. For the purposes of BIS, abuse of legal substances means that for the beneficiary, using the legal substance creates a barrier to participating in and benefitting from intensive rehabilitation services.

2.3 Additional Beneficiary Records

In addition to medical records that support the medical eligibility requirements described above, the following beneficiary records, as applicable, must be submitted for consideration of approval of BIS:

- Emergency Room records for the brain injury;
- The initial post-injury computed tomography scan, magnetic resonance imaging or other report of brain;
- Neurological consultations and surgery reports related to the brain injury;
- Therapy notes including therapist evaluations;
- Social worker evaluation;
- A statement by a qualified health professional that indicates the beneficiary has functional or cognitive limitations as a direct result of the brain injury;
- Proof of guardianship or power of attorney, if applicable;
- Other documents relative to the beneficiary and their brain injury; and
- Acknowledgement (written or oral) from a qualified provider indicating a willingness to admit the beneficiary.

2.4 Submission of Records to MDHHS

MDHHS HCBS staff will review the documentation submitted to ensure the individual meets eligibility criteria. The standard of promptness for MDHHS to make an eligibility determination is ten (10) business days from receipt of a complete referral packet. Providers must plan for at least this amount of time before confirmation of approval for BIS. Submission of complete admission packets will facilitate the determination process.

In the cases where an applicant for the BIS program does not meet BIS eligibility criteria, BIS providers must send documentation to MDHHS with evidence that the individual does not meet BIS criteria. Only MDHHS can approve or deny eligibility for BIS.

2.5 MDHHS Approval

Once eligibility is verified and a qualified provider is located, MDHHS will approve BIS for up to 90 days for the beneficiary. MDHHS will provide a list of qualified BIS providers to assist the applicant in making an informed choice of providers.

2.6 Provider Responsibilities

Upon acceptance of the beneficiary, the provider agrees to do the following:

- Submit a copy of the beneficiary's Plan of Care (POC) within two weeks of admission;
- Submit any changes, reductions, or terminations in services listed in the POC to MDHHS HCBS staff at least two weeks prior to the effective date for MDHHS approval. This will allow MDHHS time to send the beneficiary proper notice. (Refer to the Appeals section for additional information.)
- Submit the Treatment Team report to MDHHS HCBS staff monthly. Reports should include progress toward discharge planning;
- Notify MDHHS HCBS staff of beneficiary hospitalizations for more than two (2) days;
- Submit a discharge plan 30 days prior to the anticipated discharge date; and
- Submit a discharge summary report within 30 days after the beneficiary's discharge from BIS.

2.7 Case Conferences

Prior to the BIS approval expiration date, MDHHS staff and the provider's treatment team will meet with the beneficiary to determine if the approval for BIS should be renewed and for how long. Renewal is based upon the beneficiary's continued ability to make progress. Renewals will not be granted if the beneficiary meets the discharge criteria. When the beneficiary continues to demonstrate progress toward rehabilitation goals, BIS may be reapproved for up to six months of Transitional Residential rehabilitation. Outpatient rehabilitation is not limited as long as the beneficiary continues to make progress toward goals identified in the POC and other Medicaid-funded services are not available to meet the individual's needs.

SECTION 3 – COVERED SERVICES

BIS covers, upon prior authorization (PA), medically necessary rehabilitation services for beneficiaries with neurological damage resulting from a brain injury. All services must be included on the beneficiary's POC. All services are available to beneficiaries in both transitional residential and outpatient settings. In addition to BIS, beneficiaries have access to Medicaid State Plan services (e.g., prosthetic and orthotic care, durable medical equipment (DME)) on a fee-for-service (FFS) basis. The following services are included as BIS when provided by or under the direction of appropriately qualified individuals.

3.1 DIAGNOSIS AND EVALUATION

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the brain injury of the beneficiary. Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the Department of Licensing and Regulatory Affairs (LARA). Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident). Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, and review and explanation of diagnostic test reports to the beneficiary. Requests for individual consideration should not report the modifier for increased procedural services with E/M services unless specifically directed by this manual. This practice does not follow Current Procedural Terminology (CPT) coding guidelines and causes longer delays in processing claims for payment.

3.2 REHABILITATIVE NURSING SERVICES

Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

A nursing visit may include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered.
- Changing an indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, family member, friend, neighbor, or caregiver (paid or unpaid) to carry out all or some of the services.
- Observation and evaluation.

Intermittent nurse visits are intended for beneficiaries who generally require nursing services for the treatment of an acute illness, injury, or disability. Intermittent nursing visits may last from 15 minutes to one or two hours.

The following nursing services are covered by BIS. Limitations, conditions and special considerations are noted when applicable.

3.2.A. Bladder Training

When use of a catheter is temporary, visits made by the nurse to change the catheter must also include instruction to the beneficiary in bladder training methods. The actual bladder training (e.g., forcing fluids or other measures) does not require the skills of a nurse. After the catheter is removed, a limited number of visits (maximum two visits per month) are allowed to observe and evaluate the effectiveness with which the bladder training has been accomplished (e.g., the degree to which the bladder is emptying).

3.2.B. Enemas

Giving enemas usually does not require the skills of a nurse, and Medicaid does not cover such visits unless the physician has ordered that a nurse gives the enema because of clinical indications.

3.2.C. Observation/Evaluation

When the attending physician determines that the beneficiary's condition is unstable and that significant changes may occur, Medicaid covers nurse visits for observation/evaluation. Once the beneficiary's condition has stabilized and there has been no significant change (e.g., no change in medication or vital signs, no recent exacerbation in the beneficiary's condition) for a period of three weeks, and no other necessary nursing services are being furnished, nursing visits solely for observation/evaluation are no longer covered.

3.2.D. Oral Medications

Administration of oral medications does not usually require the skills of a nurse in the home setting. Visits are covered only if the complexity of the beneficiary's condition and/or the number of drugs prescribed require the skill or judgment of a nurse to detect and evaluate side effects (adverse reactions) and/or provide necessary teaching and instruction.

Placing medication in envelopes/cups, giving reminders, etc. to assist the beneficiary in remembering to take them does not constitute a nursing service.

3.2.E. Routine Prophylactic and Palliative Skin Care

The recognized stages of decubitus ulcers are classified as:

- Stage I - Inflammation or redness of the skin;
- Stage II - Superficial skin break with erythema of surrounding area;
- Stage III - Skin break with deep tissue involvement; and
- Stage IV - Skin break with deep tissue involvement with necrotic tissue present.

The existence of Stage III or Stage IV decubiti or other widespread skin disorders may necessitate the skills of a nurse. The physician's orders for treating the skin determine the need for this service. The presence of Stage I or Stage II decubiti, rash, or other

relatively minor skin irritations do not indicate a need for nursing care unless ordered by a physician. Bathing the skin, applying creams, etc. are not covered nursing services.

3.2.F. Teaching and Training Activities

Medicaid covers home health aide teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability. Eligibility for teaching visits must take into account the ability of a recipient or family member to comfortably perform the task(s) taught.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection
- Prefilling insulin syringes
- Inserting/irrigating a catheter
- Administering eyedrops/topical ointments
- Caring for a colostomy or ileostomy
- Administering oxygen
- Preparing and following a therapeutic diet
- Applying dressings to wounds that require prescription medications and aseptic techniques
- Bladder training
- Bowel training (e.g., bowel incontinency, constipation due to beneficiary's immobility)
- Performing activities of daily living (e.g., dressing, eating, personal hygiene) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has experienced a loss of function
- Aligning and positioning a bed-bound beneficiary
- Performing transfer activities (e.g., from bed to chair or wheelchair, wheelchair to bathtub)
- Ambulating by means of crutches, walker, cane, etc.

Medicaid reimbursement for teaching visits is based on whether the teaching provided in the home is a reinforcement of previous teaching or is initial instruction. If teaching constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training.

Visits made solely to remind or emphasize to the beneficiary, family member, friend, or neighbor the need to follow the instructions are not covered services. However, visits are covered when they include supervision and evaluation of complex care that initially requires training by a nurse (e.g., insulin injections or preparation of formula feedings for gastrectomy beneficiaries).

Whether the teaching is reinforcement or initial, the nurse must establish the goal(s) or intended outcome(s) for the beneficiary and a reasonable period of time to attain them and document these in the POC. The beneficiary must be encouraged to become independent of skilled services in their home whenever feasible.

3.3 Cognitive Rehabilitation Services

MDHHS uses the terms cognitive rehabilitation services, cognitive rehabilitation therapy (CRT), CRT and therapy interchangeably. CRT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed cognitive rehabilitation therapist;
- A licensed and certified speech-language pathologist (refer to the Speech Language Services subsection for additional information); or
- A qualified licensed practitioner (refer to the Behavioral and Psychological Services subsection for additional information).

Cognitive rehabilitation services assist the beneficiary with relearning cognitive skills that have been lost or altered because of the brain injury. When skills cannot be relearned, new skills must be taught to enable the beneficiary to compensate for their lost cognitive functions. Cognitive rehabilitation comprises four components:

- Education about cognitive weaknesses and strengths, focusing on developing awareness of the problem.
- Process training or the development of skills through direct retraining or practicing the underlying cognitive skills. The goal of process training is to resolve the deficit.
- Strategy training involves the use of environmental, internal and external strategies to assist with compensating for the deficit rather than resolving the problem.
- Functional activities training applies the above three components (education, process training, and strategy training) in everyday life so that the beneficiary regains independence to the greatest extent possible.

Cognitive rehabilitation achieves functional changes by:

- Reinforcing, strengthening or establishing previously learned patterns of behavior.
- Establishing new patterns of cognitive activity or mechanisms to compensate for impaired neurological systems.
- Interventions that are tailored to help the beneficiary be as independent as possible in the management of their everyday routines and responsibilities in their home and community.

The cognitive rehabilitation therapist will evaluate the beneficiary to understand the beneficiary's unique needs and concerns and to create a treatment plan that describes how cognitive rehabilitation will assist the beneficiary to learn to use tools and strategies to be as independent as possible. The evaluation may include standardized or non-standardized assessments, questionnaires, testing, interviews, or observation to gain the greatest understanding of the beneficiary's abilities and limitations in managing everyday routines and responsibilities.

The beneficiary's treatment plan will summarize the beneficiary's strengths and limitations. The treatment plan will include all the activities that will help the beneficiary remediate or compensate for limitations. The therapist will continually assess the beneficiary's progress and revise goals based on that progress.

3.4 Physical Therapy Services

MDHHS uses the terms physical therapy (PT), PT and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed physical therapist;
- An appropriately supervised licensed physical therapy assistant; or
- A student completing a clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed physical therapist may also be covered. All documentation must be reviewed and signed by the supervising physical therapist.

PT must be medically necessary and reasonable for the maximum reduction of physical disability and restoration of a beneficiary to their best possible functional level.

MDHHS anticipates PT will result in significant functional improvement in the beneficiary's ability to perform mobility skills appropriate to their chronological, developmental, or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). PT that makes changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.

PT must be skilled (i.e., require the skills, knowledge and education of a physical therapist). MDHHS does not cover PT interventions provided by non-PT practitioners (e.g., teacher, RN, occupational therapist, family, or caregiver).

MDHHS covers the physical therapist's initial evaluation of the beneficiary's needs and design of the PT program. The program must be appropriate to the beneficiary's capacity, tolerance, treatment objectives, and include the instructions to the beneficiary and support personnel (e.g., aides or nursing personnel) for delivery of the individualized treatment plan. MDHHS covers infrequent reevaluations, if appropriate.

The cost of supplies and equipment used as part of the therapy program is included in the reimbursement for the therapy. Skilled PT services are designed to set up, train, monitor, and modify a maintenance or prevention program to be performed by family or caregivers. MDHHS does not reimburse for routine provision of the maintenance/prevention program. MDHHS only covers a clinic room charge in addition to PT if it is unrelated.

PT services may be covered for one or more of the following reasons:

- PT is expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills;
- PT service is diagnostic;
- PT is for a condition that creates decreased mobility and/or function; and/or

- To prevent a reduction in medical or functional status had the therapy not been provided.

PT may include:

- Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility);
- Stretching for improved flexibility;
- Instruction of family or caregivers;
- Modalities for pain relief and inflammation reduction;
- Modalities to allow gains of function, strength, balance or mobility; and/or
- Training in the use of orthotic/prosthetic devices.

3.5 Occupational Therapy Services

MDHHS uses the terms occupational therapy (OT), OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and performed by:

- A licensed occupational therapist;
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant's services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the appropriate supervising occupational therapist; or
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed occupational therapist. All documentation must be reviewed and signed by the supervising occupational therapist.

OT is considered an all-inclusive charge and MDHHS does not reimburse for a clinic room charge in addition to OT services unless it is unrelated. MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law and/or the appropriate national professional association. OT must be medically necessary, reasonable and required to:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; or
- Prevent a reduction in medical or functional status had the therapy not been provided.

MDHHS anticipates that OT will result in a functional improvement that is significant to the beneficiary's ability to perform appropriate daily living tasks (per beneficiary's chronological, developmental, or functional status). Functional improvements must be achieved in a reasonable amount of time and must be maintainable.

OT must be skilled (i.e., require the skills, knowledge and education of a licensed occupational therapist). MDHHS does not cover OT interventions provided by non-OT practitioners (e.g., teacher, RN, licensed physical therapist, family, or caregiver).

3.6 Speech Language Services

The terms speech therapy, speech-language pathology, speech-language therapy, and therapy are used to mean speech and language rehabilitation services and speech-language therapy.

MDHHS covers speech-language therapy provided in both transitional residential and outpatient settings. MDHHS only reimburses services for speech-language therapy when provided by:

- A speech-language pathologist (SLP) with a current license.
- An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY]). All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.
- A student completing their clinical affiliation under direct supervision of (i.e., in the presence of) an SLP having a current license. All documentation must be reviewed and signed by the appropriately credentialed supervising SLP.

MDHHS expects that all SLPs will utilize the most ethically appropriate therapy within their scope of practice as defined by Michigan law and/or the appropriate national professional association.

Speech-language therapy must relate to a medical diagnosis, and is limited to services for:

- Articulation
- Language
- Fluency
- Swallowing
- Training in the use of a speech-generating device
- Training in the use of an oral-pharyngeal prosthesis
- Voice
- Cognition

Therapy must be reasonable, medically necessary and expected to result in an improvement and/or elimination of the stated problem within a reasonable amount of time (i.e., when treatment is due to a recent change in medical or functional status affecting speech and the beneficiary would experience a reduction in medical or functional status without therapy).

Speech-language therapy services must be skilled (i.e., require the skills, knowledge and education of a licensed SLP to assess the beneficiary for deficits, develop a treatment program and provide therapy). Interventions that could be provided by another practitioner (e.g., teacher, RN, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be reimbursed as speech therapy by MDHHS. (Refer to the Therapy Services Chapter of this manual for additional information regarding therapy services.)

3.7 Social Work Services

Social work services include the provision of assistance and advocacy to improve the social and psychological functioning of the beneficiary.

MDHHS covers social work services provided in both transitional residential and outpatient settings. MDHHS only reimburses services for social work services when provided by:

- A social worker with a current Michigan license;
- An appropriately supervised social work candidate (i.e., in their clinical fellowship year) or having completed all requirements but has not obtained a license. All documentation must be reviewed and signed by the appropriately credentialed supervising Master of Social Work (MSW); or
- A student completing their clinical affiliation under direct supervision of (i.e., in the presence of) a licensed MSW. All documentation must be reviewed and signed by the appropriately credentialed supervising MSW.

Services may include, but are not limited to, advising family members and caregivers, providing patient education and counseling, beneficiary advocacy, making referrals to other services, case management interventions, and discharge planning.

3.8 Behavioral and Psychological Services

A diagnostic evaluation must be performed before the beneficiary receives behavioral and psychological services (BPS). The diagnostic evaluation is a thorough review of cognitive, behavioral, emotional, and social functioning, and includes validated evaluation tools. Based on the evaluation, the practitioner determines the beneficiary's diagnosis and recommends general treatment interventions. If appropriate, the practitioner refers the beneficiary to a comprehensive neuropsychological evaluation or medical evaluation with a psychiatrist for consideration of psychiatric medication (refer to the Neuropsychological Evaluation and the Psychiatry subsections below) for holistic treatment of the psychological condition(s).

The diagnostic evaluation is performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing individuals with brain injuries.

A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry;
- a physician with a specialty in behavioral health;
- a psychologist;
- a neuropsychologist; or
- a clinical social worker working within their scope of practice who is qualified and experienced in diagnosing behavioral health issues related to brain injuries.

Medical necessity and recommendation for BPS is determined by a physician or other licensed practitioner working within their scope of practice under state law. The beneficiary must demonstrate functional impairment in social, occupational, or other important areas of functioning, and/or report significant subjective distress associated with changes following the brain injury. Common cognitive, behavioral, emotional, and social changes following a brain injury require BPS to address the following areas:

- Trauma- and Stressor-Related Disorders:
  - in response to a traumatic event, individual experiences intrusive symptoms (recurrent distressing memories of the traumatic event, distressing dreams or flashbacks related to the traumatic event);
  - negative mood (persistent inability to experience positive emotions);
  - dissociative symptoms (altered sense of reality of one's surroundings or oneself);
  - inability to remember an important aspect of the traumatic event;
  - avoidance symptoms (efforts to avoid distressing memories, thoughts, or feelings about the traumatic event);
  - efforts to avoid external reminders of the traumatic event; and
  - arousal symptoms (sleep disturbance, irritable behavior, hypervigilance, problems with concentration, exaggerated startle response).
- Anxiety and Obsessive-Compulsive Disorders:
  - excessive fear or anxiety about a specific object or situation;
  - recurrent, unexpected panic attacks (abrupt surge of intense fear or intense discomfort);
  - marked fear or anxiety about using public transportation, being in open or enclosed spaces, being in a crowd, or being outside of the home alone;
  - difficulty controlling worry about a number of events or activities;
  - recurrent and persistent thoughts or urges that are intrusive and unwanted; and
  - repetitive behaviors performed in response to an obsession.
- Depressive Disorders:
  - depressed mood most of the day, nearly every day;
  - diminished interest or pleasure in activities;
  - weight fluctuations;
  - sleep pattern disruption;
  - psychomotor agitation or slowing;
  - fatigue or loss of energy;
  - feelings of worthlessness or excessive guilt;
  - diminished ability to think or concentrate;
  - recurrent thoughts of death; and
  - severe recurrent temper outbursts manifested verbally and/or behaviorally.
- Neurocognitive Disorders:
  - significant cognitive decline from a previous level of performance in areas of attention, executive function, learning and memory, language, perceptual-motor, or social cognition; and

- the cognitive deficits interfere with independence in everyday activities.

- Personality Disorders:
  - persistent personality disturbance due to a medical condition that may include affective lability, disinhibition, aggression, apathy, or paranoia; and
  - the disturbance causes distress or impairment in social, occupational, or other important areas of functioning.
- Somatic Symptoms and Related Disorders:
  - excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns;
  - disproportionate and persistent thoughts about the symptoms;
  - high level of anxiety about the symptoms;
  - excessive time and energy devoted to these symptoms or health concerns;
  - symptoms of altered voluntary motor or sensory function (weakness, paralysis, tremors, speech difficulties, attacks or seizures, sensory loss); and
  - psychological or behavioral factors adversely affect the medical condition.

3.8.A. Neuropsychological Evaluation

A qualified licensed practitioner performing the initial evaluation for BPS may determine the need for a more comprehensive psychological evaluation by a neuropsychologist. The Neuropsychological Evaluation (NPE) is a comprehensive evaluation of cognitive, academic, emotional, social, and adaptive functioning using standardized measures. The NPE may assist with treatment planning, progress monitoring, academic or occupational planning, or necessity of a guardian or conservator. The NPE may be initiated immediately following the injury, at various points throughout treatment to monitor progress, or following the completion of treatment to plan for transition to the next step in the beneficiary's recovery.

3.8.B. Psychiatry

A referral to a psychiatrist with experience in working with individuals with brain injuries may be a necessary component of rehabilitation. The beneficiary may experience significant disruption in social, occupational, or other areas of functioning, or may report significant emotional distress resulting from the injuries. Medication may be indicated for those beneficiaries whose symptoms are significantly impairing daily tasks, interfering with treatment engagement, or not responding to evidence-based interventions at a level expected for the provided treatment. These situations may warrant a referral for an evaluation by a psychiatrist for determination of an appropriate medication regimen.

3.8.C. Psychological Treatment

BPS includes a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and other nationally recognized scientific and clinical evidence. BPS is designed to be delivered at a

frequency and intensity appropriate for the clinical presentation of the beneficiary. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- Cognitive Behavioral Therapy: Identifying maladaptive cognitions and patterns of behavior as a means of teaching healthy coping skills in response to stressful events.
- Exposure and Response Prevention: Systematically exposing the beneficiary to the stressful images, thoughts, or situations that provoke anxiety and teaching more adaptive responses.
- Acceptance and Commitment Therapy: Accepting thoughts and feelings as they are while identifying behaviors consistent with the beneficiary's values.
- Mindfulness-Based Treatment: Practicing a state of being psychologically present using meditation and breathing exercises to target depression and anxiety.
- Family Therapy: Teaching communication techniques and adaptability within the family unit to promote positive behaviors, connection to each other, and positive identity of each member.

The treatments and interventions listed above are not all-inclusive. BPS treatment services may also include other interventions supported by credible scientific or clinical evidence, as appropriate for each beneficiary. Based on the behavioral POC, which is adjusted over time based on progress monitoring, collaboration with other providers of care, and behavioral observations during treatment, the provider selects and adapts one or more of these services, as appropriate for the beneficiary.

3.9 Rehabilitation Aide Services

Rehabilitation Aide Services include unskilled assistance improving skills and functioning. The rehabilitation aide assists the beneficiary with meeting therapy goals and reinforcing skills learned during therapy sessions. A rehabilitation aide also provides personal care services, including help with bathing, toileting, and dressing.

SECTION 4 – APPEALS

MDHHS has established beneficiary and provider appeal processes that are applicable to BIS. The beneficiary appeals process conforms to the Medicaid fair hearing requirements found at 42 CFR Part 431, Subpart E of the Code of Federal Regulations. Provider appeal rights conform to the requirements of the Michigan Compiled Laws, MCL 400.1 et seq., and the administrative rules found at Michigan Administrative Code R 400.3402 through R 400.3425, as amended.

4.1 PARTICIPANT APPEALS

MDHHS has established notice and appeals requirements to which BIS providers must adhere when adverse action has been taken for program applicants or beneficiaries. According to 42 CFR 431.201, "Action" means a termination or suspension of Medicaid eligibility or of covered services. This also includes determinations by MDHHS that the applicant does not meet BIS eligibility criteria and other denials of Medicaid eligibility or of covered services. The beneficiary will be notified in writing of the negative action and the right to appeal.

4.1.A. ADEQUATE ACTION NOTICES

MDHHS HCBS staff will send an Adequate Action Notice to applicants or beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- when MDHHS staff determine applicants to be ineligible for BIS based upon the information provided in the application packet.
- when MDHHS staff determine an individual receiving BIS will have services end as planned in the authorization.
- when an existing benefit is reduced, suspended or terminated and meets the requirements for an exception from an Advance Action Notice as specified in 42 CFR 431.213.

BIS providers must confer with MDHHS HCBS staff prior to refusing, refusing to increase, or reducing services. MDHHS makes the final determination on furnishing, reducing, and refusing services. Upon approval of an adverse action, MDHHS HCBS staff must send an Adequate Action Notice to applicants or beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- when the provider refuses to furnish a requested service to a program applicant.
- when the provider refuses to increase a service that is currently being provided to the beneficiary.
- when the provider reduces a service that is currently being provided to the beneficiary and this reduction follows the approved POC for the beneficiary.

4.1.B. Advance Action Notices

An Advance Action Notice must be sent to BIS beneficiaries when action is being taken to reduce, suspend or terminate service(s) a beneficiary currently receives. This notice must be provided 10 days in advance of the intended action.

MDHHS HCBS staff will send an Advance Action Notice to beneficiaries informing them of adverse actions and determinations taken under the following circumstances:

- When MDHHS staff determine the beneficiary is making progress toward goals and will be discharged from BIS.
- When MDHHS staff determine an individual no longer qualifies for BIS.
- When the provider (with permission from MDHHS) plans to reduce or terminate a service that is currently being provided to the beneficiary before the POC indicates.

The Advance Action Notice must inform the beneficiary that services will not be reduced, suspended or terminated until a formal decision has been rendered through the Medicaid Fair Hearings process if the beneficiary formally requests a hearing before the specified date of the intended action.

4.1.C. Request for Hearing Form

MDHHS will supply a copy of the Request for Hearing form (DCH-0092) and a return envelope with each notice sent to an applicant or beneficiary, or any time an applicant or beneficiary requests such material. Providers are required to assist applicants or beneficiaries who request help in filing a formal appeal for any reason through the Medicaid Fair Hearings process.

4.1.D. Representation at State Fair Hearing

Both a BIS provider representative and a MDHHS HCBS Section or Long Term Care Policy Section representative must be present at the hearing. The BIS provider will be expected to participate in the State Fair Hearings process to support medical documentation used to make determinations related to the hearing request.

SECTION 5 – PROVIDERS

5.1 PROVIDER QUALIFICATIONS

In addition to provider qualifications identified above in the Covered Services section, all providers for BIS must have appropriate accreditation, certifications, or specialized training in serving individuals with brain injuries.

5.1.A. ACCREDITATION, CERTIFICATION, OR SPECIALIZED TRAINING

Appropriate accreditation, certification, or specialized training includes:

- Accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) with:
  - Medical Rehabilitation accreditation as a brain injury specialty residential program;
  - Medical Rehabilitation accreditation as a brain injury specialty interdisciplinary outpatient service; or
  - Medical Rehabilitation accreditation as a brain injury specialty residential program and interdisciplinary outpatient services.
- Medicare and Medicaid certification as a Comprehensive Outpatient Rehabilitation Facility (CORF).
- Medicare accreditation as a Rehabilitation Agency or Outpatient Physical Therapy program as verified by the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF).
- In areas of the state where there are limited providers with CARF, CORF, or AAAASF accreditation or certification, MDHHS may allow individual providers who are certified as Brain Injury Specialists (CBIS) through the Brain Injury Association of America's Academy of Certified Brain Injury Specialists (ACBIS) and who work in a health care program with additional licensing or accreditation to become brain injury providers.

5.1.B. PROVIDER ENROLLMENT IN CHAMPS

All providers must follow provider enrollment requirements as specified in the General Information for Providers chapter of this manual, including business location, provider ownership and control disclosures, criminal offense notification, and enrollment screening.

5.1.C. TRANSITIONAL RESIDENTIAL PROVIDER REQUIREMENTS

Transitional Residential services must be conducted in facilities licensed by MDHHS as adult foster care (AFC) facilities.

5.1.C.1. LICENSURE REQUIREMENTS

All AFC homes must maintain current licensure and follow all licensing rules and regulations, including staff qualifications and training. Direct care staff will provide supportive services for each beneficiary 24 hours a day. The ratio of direct care staff is

required to meet the acuity needs of the beneficiaries, but will not be less than one staff to five residents on day and evening shifts and one staff to eight residents during sleeping hours. Substitute employees may only be used in the case of an unexpected staff shortage. The continuity and consistency of the residents' care must be preserved to ensure maximum restorative rehabilitation progress.

5.1.C.2. Additional Staffing Requirements

- A Michigan-licensed therapist must be on the premises during the time therapy is provided.
- A Michigan-licensed RN must be available for health assessments, treatments, and other nursing needs required by the residents.
- A Michigan-licensed social worker must be available for assisting in discharge planning, counseling, or other needs.
- Psychiatrists, neuropsychologists, psychologists, and other specialists must be available for consultation and treatment as needed. Evidence of appropriate availability must be documented.

5.1.C.3. Provider Case Record Requirements

All BIS providers are required to keep case records for each beneficiary served according to acceptable standards of practice.

SECTION 6 – REIMBURSEMENT

Reimbursement for Transitional Residential BIS will be according to per diem rates, negotiated with the BIS providers, which reflect the service needs of the beneficiary and a reasonable cost basis for the services rendered. PA is required for the Transitional Residential BIS per diem reimbursement. Requests for PA are submitted for days of services, not for individual services (for example, PA request is for 60 days of BIS, regardless of services provided). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. (Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)

Reimbursement for Outpatient BIS will be according to a published fee schedule based upon the services received by the beneficiary. PA is required for Outpatient BIS reimbursement. Requests for PA are submitted for individual services for a specified duration (for example, PA request is for 30 days of physical therapy BIS for eight 15-minute units per day). Providers should contact the MDHHS HCBS Section regarding BIS authorization requirements. (Refer to the Prior Authorization section of the General Information for Providers chapter of this manual for additional information.)

6.1 EXCLUDED PAYMENTS

BIS does not include payment for room and board. "Room" is defined as rent and lodging expenses. "Board" is defined as three meals per day, regardless of the method of intake for those meals.

BIS also excludes educational services, such as tutoring assistance and school-based services, and vocational services, such as services to train or build skills for the support of the individual's employment. These services are available to qualified Medicaid beneficiaries through other Medicaid programs and services.

6.2 BILLING REQUIREMENTS

BIS providers must follow the requirements of the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters of this manual.

6.3 BILLING BENEFICIARIES

BIS providers are not allowed to bill Medicaid beneficiaries for services authorized by MDHHS. Additional information about billing beneficiaries is found in the Billing Beneficiaries section of the General Information for Providers chapter of this manual.

CHILDREN'S SPECIAL HEALTH CARE SERVICES

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SECTION 1 – GENERAL INFORMATION

CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. CSHCS is a separate program from Medicaid.

However, CSHCS partners closely with the Medicaid program regarding the use of the Medicaid system. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary to avert duplication of services. CSHCS does not pay for Medicaid-covered services that have been denied by Medicaid.

CSHCS is charged by the Social Security Act, Title V, Maternal and Child Health Office with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally-competent with a focus on health equity. CSHCS strives for having the most appropriate pediatric subspecialists and services that are identified by combining the family's expertise regarding their child and the condition, the medical services provider, MDHHS medical expertise, and CSHCS policy and program intent.

CSHCS increases access to resources and supports for the families and beneficiaries. Services occur in partnership, recognizing the family as the constant in the child's life. The goal is to reduce or eliminate barriers that are inherent to the condition. This, in turn, is intended to increase the quality of life for the beneficiary and the family. This family-centered approach impacts the level of independence most beneficiaries are able to achieve.

CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental or mental health conditions. The child's pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility. When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The beneficiary may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria, and the need for treatment by a pediatric subspecialist before the beneficiary can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility (and allowable citizenship/permanent residency status) must be established by MDHHS before the beneficiary can enroll in CSHCS.

Once enrolled, CSHCS covers pediatric specialty medical treatment (adult specialty for the few enrolled adults) related to the qualifying condition. Care is limited to the qualifying diagnosis and related conditions. The limitation occurs by authorizing particular specialty providers for each child and having the authorized provider(s) order additional services, such as therapies, lab tests, etc., as needed as related to their specialty. Providers who are not CSHCS-authorized are not eligible for reimbursement. CSHCS does not cover primary care or condition-related care delivered by a primary care provider.

NOTE: CSHCS and Medicaid interface – CSHCS follows Medicaid policy except where specified in this chapter. Many of the CSHCS processes (e.g., prior authorizations, medical determinations, claims, etc.) are integrated into the Medicaid system and processes for CSHCS beneficiaries.

CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid.

CSHCS also partners with Medicaid when beneficiaries have both CSHCS and Medicaid. Most beneficiaries who also have Medicaid are required to enroll with a Medicaid Health Plan. Under this situation, medical coverage is subject to the Medicaid rules. CSHCS can, at times, provide additional services beyond what is available through the Medicaid benefit package. These services include care coordination, the development of a plan of care in which the family participates, referral to appropriate medical providers, and assistance with locating, accessing, and navigating community support services, etc.

SECTION 2 – CSHCS PROVIDERS: APPROVED/AUTHORIZED

In addition to enrollment with the Michigan Medicaid Program, physicians and hospitals serving beneficiaries must meet criteria to serve as a CSHCS specialty care provider. The criteria are detailed in the CSHCS Approved Providers subsection below.

All providers must comply with Medicaid policies and requirements, including prior authorization requirements described elsewhere in this manual.

For beneficiaries without Medicaid/MIChild/Healthy Michigan Plan coverage, approved physicians and/or hospitals (including hospital-owned ambulance and hospice agencies) must also be authorized by CSHCS to provide medical services related to the beneficiary's CSHCS qualifying condition. (Refer to the CSHCS Authorized Providers subsection for authorization requirements.)

2.1 CSHCS APPROVED PROVIDERS

2.1.A. PHYSICIANS

Physicians desiring to be CSHCS approved specialty care providers must:

- Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.
- Have successfully completed medical residency.
- Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved.)
- Be enrolled in the Michigan Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)
- Have clinical privileges in a CSHCS approved hospital/facility.
- Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.

2.1.B. HOSPITALS

Hospitals desiring to be CSHCS approved must:

- Be enrolled in the Michigan Medicaid program (refer to the General Information for Providers Chapter of this manual for additional information);
- Have an organized Pediatrics Unit with an average daily census of six (6) or greater; and
- Have a Pediatrics Department identified in the medical staff structure.

Exceptions:

- Local laboratory and/or local imaging services ordered by the CSHCS subspecialist during the hospital visit and emergency care are not required to meet the organized Pediatrics Unit requirement, as stated above.
- Emergency services do not require an order by the CSHCS subspecialist.

2.2 CSHCS Authorized Providers

The following requirements apply only to providers serving CSHCS beneficiaries who do not also have Medicaid/MIChild/Healthy Michigan Plan coverage:

- An authorized provider is an approved physician and/or hospital that is specifically identified on the CSHCS system as a provider for a specific beneficiary. (Refer to the CSHCS Approved Providers subsection for participation requirements.)
- CSHCS authorization of a provider is the step that allows for reimbursement for medical services rendered that are related to the CSHCS qualified condition(s).
- To become CSHCS authorized for a specific beneficiary, the family or the provider contacts the county health department in which the beneficiary lives.

Providers serving beneficiaries with CSHCS who also have Medicaid/MIChild/Healthy Michigan Plan coverages do not need to be authorized.

2.3 Providers Who Do Not Need to be CSHCS Authorized

Non-physician providers typically do not need CSHCS authorization to render services to a beneficiary (except for hospital-owned ambulances and hospice agencies).

These providers may render services (and be reimbursed) when ordered or prescribed by a CSHCS authorized provider and the services are related to the beneficiary's CSHCS qualifying diagnosis.

The National Provider Identifier (NPI) number of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.

2.4 Verifying Provider Authorization

Authorized provider and diagnosis information can be obtained from the beneficiary's Client Eligibility Notice. The CHAMPS Eligibility Inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services for the beneficiary on that date of service. Providers will receive the Benefit Plan ID of CSHCS along with one of the following messages in the eligibility response:

- This NPI is listed. See CSHCS guidelines.
- This NPI is not listed. See CSHCS guidelines.

(Refer to the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.)

2.5 Children's Multi-Disciplinary Specialty (CMDS) Clinic Requirements

CMDS clinics are required to operate under the authority of hospitals or medical universities. Hospitals and medical universities requesting CMDS clinic designation must adhere to the requirements as stated in this policy and acquire approval and oversight from the CSHCS program. Hospitals and medical universities that administer CMDS clinics require a separate National Provider Identifier (NPI) number with which to enroll and submit claims specifically for the CMDS clinic fee.

CSHCS-approved organizations with responsibility for CMDS clinics must enroll through the online MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for clinic fees for services rendered to eligible beneficiaries. Each CMDS clinic must operate under the unique CMDS National Provider Identifier (NPI) held by the organization responsible for those CMDS clinics and must identify the providers who render the services in the CMDS clinic as affiliated providers. All affiliated providers whose services are directly reimbursable per MDHHS policy must be separately enrolled in CHAMPS and must also receive a beneficiary-specific authorization from CSHCS prior to the clinic billing for the clinic fees.

Refer to the General Information for Providers chapter for additional provider enrollment information.

SECTION 3 – MEDICAL ELIGIBILITY

CSHCS covers over 2,700 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist. A current list of covered diagnoses is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- Have at least one of the CSHCS qualifying diagnoses.
- Be within the age limits of the program:
  - Under the age of 26; or
  - Age 26 and above with cystic fibrosis, hereditary coagulation defects commonly known as hemophilia, or hereditary red blood cell disorders commonly known as sickle cell disease.
- Meet the medical evaluation criteria during the required medical review period as determined by a MDHHS medical consultant regarding the level of severity, chronicity and need for treatment. (Refer to the Medical Renewal Period subsection of the Coverage Period section of this chapter.)

A MDHHS medical consultant conducts the medical determination by reviewing the written report of a physician subspecialist. The medical information may be provided to CSHCS in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF) (MSA-4114). (A copy of the form is available in the Forms Appendix.) Medical information is reviewed in the context of current standards of care, as interpreted by a MDHHS medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:

Diagnosis	The individual must have a CSHCS qualifying diagnosis where their activity is or may become so restricted by disease or other medical condition as to reduce their normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are not conditions covered by the CSHCS Program.
Severity of Condition	The severity criteria is met when it is determined by the MDHHS medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or other medical condition as to reduce the individual's normal capacity for education and self-support.
Chronicity of Condition	A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.
Need for Treatment by a Physician Subspecialist	The condition must require treatment by a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.

CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through the network of the respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

Medical information submitted for the purpose of renewing CSHCS eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status.

Covered medical diagnostic categories include, but are not limited to:

- Cardiovascular Disorders
- Certain chronic conditions peculiar to newborn infants
- Congenital anomalies
- Digestive Disorders
- Endocrine Disorders
- Genito-Urinary Disorders
- Immune Disorders
- Late effects of injuries and poisonings
- Musculoskeletal Disorders
- Neoplastic Diseases
- Neurologic Disorders
- Oncologic and Hematologic Disorders
- Respiratory Disorders
- Special Senses (e.g., vision, hearing)

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care, primary care, well child visits, or immunizations (with the exception of seasonal influenza and COVID-19). Examples of diagnoses, conditions or procedures not covered include, but are not limited to:

- Acne
- Allergies, without anaphylaxis
- Anorexia Nervosa
- Appendicitis
- Attention Deficit Disorder
- Autism
- Behavioral Problems
- Bronchitis (acute), croup
- Childhood Illnesses (measles, mumps, chicken pox, scarlet fever, etc.)
- Cosmetic Surgery
- Depression
- Developmental Delay
- Headache, migraines
- Hernia (inguinal or umbilical)
- In utero treatment
- Pneumonia
- Refractive Errors and Astigmatism
- Sinusitis
- Tonsillitis, strep throat

SECTION 4 – APPLICATION PROCESS

When the MDHHS medical consultant determines the individual is medically eligible for CSHCS, MDHHS sends the individual a Children's Special Health Care Services Application (MSA-0737). The individual must complete the application and return it to MDHHS to be considered for enrollment in the program. (Refer to the Directory Appendix for contact information.) Applications submitted by the family cannot be processed until medical eligibility has been determined by MDHHS.

Applications must be signed by the medically eligible individual (when legally responsible for self) or the person(s) who is legally responsible for the individual. Verification of court-appointed guardianship may be required.

Stepparents are not considered the legally responsible persons to sign the application unless the stepparent is in the legal process of adopting the child or is the child's court-appointed guardian.

The application must be completed and submitted to MDHHS as directed on the application form. MDHHS will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of the MDHHS letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required time frame may result in the coverage date being delayed.

When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid, MIChild or Healthy Michigan Plan coverage, and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.

SECTION 5 – FINANCIAL DETERMINATION

MDHHS reviews the CSHCS Income Review/Payment Agreement (MSA-0738) submitted by all* individuals to evaluate the family/individual financial resources. The review serves to:

- Determine whether the family/individual income is sufficient to establish a payment agreement to pay toward the costs of the medical care received through CSHCS.
- Aid in identifying additional services or benefits for which the family/individual may be eligible.

5.1 FINANCIAL DETERMINATION PROCESS

Families/individuals are exempt from a payment agreement if at least one of the following applies:

- The beneficiary to be covered has full Medicaid coverage or is enrolled in MIChild or the Healthy Michigan Plan;
- The beneficiary is a ward of the county or state;
- The beneficiary lives in a foster home or a private placement agency;
- The beneficiary has a court-appointed guardian; or
- The beneficiary is deceased (retroactive coverage).

When more than one individual in the family is applying for CSHCS coverage, or already has CSHCS coverage, each individual must be determined exempt as indicated above for the family to be exempt. When any individual in the family fails to meet the exemption criteria, the family will have a payment agreement.

The MSA-0738 must be completed and submitted, when applicable, either indicating the family/individual status is exempt from a payment agreement, or with the responsible party's income and family size as reported on the federal income tax return (Form 1040, 1040A, or 1040EZ) from the previous year. If no federal income tax return is available, families may contact the local health department (LHD) or the CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

5.2 VERIFICATION OF INCOME

Families/individuals self declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected family/individual financial documentation are conducted. When the information submitted is problematic to completing the payment participation determination, or when a family/individual is randomly selected for verification of income, their federal income tax return may be requested. When the federal income tax return is not available, the family/individual may contact the LHD or CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

* Individuals determined medically eligible based on documentation submitted by their Medicaid Health Plan (MHP) are not required to submit the MSA-0738 as MHP enrollment is pre-verification of Medicaid coverage resulting in exemption from a payment agreement.

5.3 Payment Agreement

CSHCS is required to determine a family's/individual's ability to pay toward the cost of the individual's care through the financial determination process. Those determined to be exempt from payment participation, as described in the Financial Determination Process subsection, are not required to pay toward the cost of care covered by CSHCS. The family/individual payment amount is established based on the income and family size reported by the responsible party on their most recent federal income tax return as indicated on the CSHCS Payment Agreement Guide (MSA-0738-B). The income is applied to a tiered scale to determine the amount of the payment agreement. The MSA-0738-B is updated at least annually.

Financial reviews occur and new payment agreements are redetermined annually and implemented (if still applicable) according to the beneficiary's CSHCS coverage period.

The MSA-0738 must be signed by the responsible party for CSHCS coverage to be implemented. The amount of the payment agreement is the total family/beneficiary financial obligation for one year, regardless of the number of family members with CSHCS coverage. The total amount of the financial obligation is due upon receipt of the payment agreement notification. The family/beneficiary is responsible for the total amount even if CSHCS coverage ends.

If a family experiences a change in income or family size during the year, they are encouraged to work with the LHD to submit an Income Review/Payment Agreement Amendment (MSA-0927). A refund may be available if the fees paid are greater than the amount due indicated on the amendment. Refunds may be prorated up to 12 months to the date of the event, though not further than the beginning of the current MSA-0738 agreement period. Payment agreement adjustments may not be applied to previous agreements. All other payments are non-refundable.

Beneficiaries who acquire full Medicaid, MIChild, or Healthy Michigan Plan coverage after enrollment into CSHCS will be reimbursed in full for any money paid toward the payment agreement that is in place for the current CSHCS coverage period. Unpaid balances may be forgiven and CSHCS coverage continued when the beneficiary has acquired full Medicaid, MIChild, or Healthy Michigan Plan coverage. Beneficiaries can call the local health department or the CSHCS Family Phone Line to request assistance with the CSHCS payment agreement. (Refer to the Directory Appendix for contact information.)

When death of a beneficiary occurs during the beneficiary's CSHCS coverage period, a notice is sent to the family that the unpaid balance is forgiven. When the family notifies MDHHS that the payment agreement has been paid ahead, in part or in full, MDHHS pro-rates the monthly amount related to the coverage period for which the beneficiary is no longer covered due to death. The family is reimbursed the pro-rated amount. When death of a beneficiary occurs and one or more of the surviving family members have CSHCS coverage, the payment agreement remains intact for the remaining family members.

A family/beneficiary may have no more than two outstanding years of incomplete or unpaid payment agreements. The family/beneficiary will not receive CSHCS coverage under a third year of a payment agreement until the oldest payment agreement obligation has been met.

When the beneficiary reaches the age of majority, or otherwise becomes emancipated, outstanding payment agreements remain with the family who entered into the original agreement. When a beneficiary acquires Medicaid, MIChild, or Healthy Michigan Plan coverage after the beneficiary reaches the age of majority, the current payment agreement entered into by the family while the beneficiary was a minor does not qualify for forgiveness of balance or return of money. The income of the legally independent beneficiary is not assessed for a payment agreement until the beneficiary's next CSHCS renewal period.

SECTION 6 – OTHER ELIGIBILITY CONSIDERATIONS

6.1 CITIZENSHIP STATUS

The individual, parent of a minor, or court-appointed guardian of the individual must be a citizen of the U.S., a noncitizen lawfully admitted for permanent residence, or a lawfully admitted migrant farm worker (i.e., temporary agricultural worker). Any individual born in the United States who meets all other program eligibility criteria is deemed eligible regardless of the citizenship status of the parents/court-appointed guardian.

- Noncitizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.
- MDHHS requires a statement of citizenship status from the family if the information is unclear from the application.
- MDHHS may request verification of citizenship or permanent resident status.

There are some exceptions by the U.S. Citizenship and Immigration Services (USCIS) that allow legal status for individuals with specific reasons for nonpermanent entry in the U.S who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

6.2 RESIDENCY

The individual, parent, court-appointed guardian, or foster parent of the individual must be:

- A Michigan resident(s); or
- Working or looking for a job in Michigan, and living in Michigan (including migrant status); or
- In Michigan with the clear intent to make Michigan their home.

A Michigan resident who is temporarily absent from the state (e.g., out-of-state college attendance, member of a family stationed out-of-state for military service, or other extenuating circumstances allowed by MDHHS) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es) meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual is known to be out-of-state (except for the circumstances listed above) even if the parent, court-appointed guardian or foster parent meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual is known to reside in a long term care facility whose rate of payment includes medical care and treatment (e.g., nursing facility, ICF/IID, inpatient psychiatric hospitals, etc.). The individual can re-apply for CSHCS coverage or have CSHCS coverage reinstated when the living arrangement changes and all other eligibility criteria are met.

SECTION 7 – EFFECTIVE DATE

The effective date of CSHCS coverage is dependent upon the date of the event that medically qualifies the individual for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event, and may be retroactive up to six (6) months from the date MDHHS receives all necessary documentation that results in a final determination of CSHCS eligibility.

When application information is missing, the individual has 30 days from the date of the letter sent from MDHHS requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. If the information is not submitted within 30 days, the effective date of coverage may be retroactive up to six (6) months from the date the required information has been submitted. Retroactive coverage does not guarantee that providers of services already rendered will accept CSHCS payment.

CSHCS does not reimburse families directly for payments made to providers.

Families/individuals are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

* Submission date is considered the date the document is received by CSHCS.

SECTION 8 – COVERAGE PERIOD

Upon completion of the application or renewal process requirement (as specified below), CSHCS coverage is typically issued in 12-month increments.

Families/beneficiaries are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MIChild, or Healthy Michigan Plan coverage are determined complete in the annual financial review each year those circumstances remain true. Beneficiaries are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.

Beneficiaries are required to apply for MIChild/Healthy Kids/Healthy Michigan Plan coverage when the Income Review/Payment Agreement (MSA-0738) indicates the beneficiary may be eligible for one of these programs based on age and family income. The Income Review/Payment Agreement is submitted at the time of the initial CSHCS application or renewal (refer to the Payment Agreement subsection). A CSHCS temporary eligibility period (TEP) of 90 days is activated to allow the family time to complete the MIChild/Healthy Kids/Healthy Michigan Plan application process.

Upon notification that the family has completed the MIChild/Healthy Kids/Healthy Michigan Plan application process, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date (begin date of the TEP), regardless of the MIChild/Healthy Kids/ Healthy Michigan Plan eligibility decision. CSHCS coverage terminates at the end of the 90-day TEP if the family fails to submit the application for one of these programs.

All coverage periods end on the last day of a month, or the beneficiary's 26th birthday if the beneficiary does not have a qualifying diagnosis that is covered beyond age 26.

8.1 MEDICAL RENEWAL PERIOD

The CSHCS medical renewal period is established at one year, two years, three years, or five years, depending upon the CSHCS primary diagnosis. Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection within this section) are required consistent with the timeframes indicated by the CSHCS medical renewal period.

When the beneficiary has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDHHS to be primary is used to determine the time interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per beneficiary. When the medical review process results in the elimination of one of the qualifying diagnoses while maintaining another diagnosis, the new coverage period is based on the timeframe associated with the new primary diagnosis.

Example: Beneficiary has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.

8.2 Partial Month Coverage

If a beneficiary enters or leaves a facility that is not a covered facility (e.g., nursing facility, or intermediate care facility) during a month of eligibility, the beneficiary remains a beneficiary for the remainder of that month. However, services provided to the beneficiary while in the facility are not covered (i.e., reimbursable) by CSHCS as these facilities are responsible for providing the medical care. (Refer to the General Information for Providers Chapter in this manual for additional information for beneficiaries who also have Medicaid coverage.)

8.3 Renewal of Coverage

The beneficiary's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the timeframes established based on the primary diagnosis for the beneficiary. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments.

SECTION 9 – BENEFITS

CSHCS covers services that are medically necessary, related to the beneficiary's qualifying diagnosis(es), and ordered by the beneficiary's CSHCS authorized specialist(s) or subspecialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter.

The primary CSHCS benefits may include:

- Ambulance
- Care Coordination*
- Case Management*
- Dental (General and Enhanced)
- Dietary Formulas (limited)
- Durable Medical Equipment (DME)
- Emergency Department (ED)
- Hearing and Hearing Aids
- Home Health (intermittent visits)
- Hospice*
- Hospital at approved sites (Inpatient/Outpatient)
- Laboratory Tests
- Medical Supplies
- Monitoring Devices (Nonroutine)
- Office Visits to CSHCS Authorized Physicians
- Orthopedic Shoes
- Orthotics and Prosthetics
- Parenteral Nutrition
- Pharmacy
- Physical/Occupational/Speech Therapy
- Radiological Procedures
- Respite*
- Telemedicine
- Transplants and Implants
- Vision

(* Refer to the information and authorization requirements stated in this Section.)

Private Duty Nursing (PDN) may be available for beneficiaries who also have Medicaid coverage.

9.1 CSHCS DENTAL BENEFITS

CSHCS beneficiaries who have a qualifying diagnosis affecting the oral cavity may be eligible to receive select dental services based on the specific diagnoses and treatment plan. All CSHCS beneficiaries do not automatically qualify for dental benefits. Covered services may include general dental services, CSHCS enhanced dental services, or both.

- CSHCS general dental services are services covered under the Medicaid dental benefit.
- CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid.

9.1.A. CSHCS General Dental Services

CSHCS general dental services may be covered for CSHCS enrollees when related to the CSHCS qualifying diagnosis. Examples of CSHCS qualifying diagnoses eligible for general dental services are identified below. The list is not all inclusive:

- Chemotherapy or radiation which results in significant dental side effects
- Cleft lip/palate/facial anomaly
- Convulsive disorders with gum hypertrophy
- Cystic Fibrosis
- Hemophilia and/or other coagulation disorders
- Pre- and post-transplant
- Sickle Cell disease

CSHCS general dental services are those services covered under the Medicaid dental benefit. Services may include diagnostic, preventive, restorative, endodontics, prosthodontics, and oral surgery. The general dental benefit may include services performed by dental specialists (e.g., endodontists, oral surgeons, etc.). General dental services follow Medicaid coverage parameters, including frequency limits, prior authorization requirements, and age restrictions.

To request approval as a CSHCS General Dentistry provider, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)

Hospital charges (e.g., general anesthesia, facility charges, etc.) may be covered for dental services provided through the inpatient or outpatient hospital facility for beneficiaries with certain CSHCS diagnoses, including cases where CSHCS does not cover the dental care itself.

9.1.B. CSHCS Enhanced Dental Services

CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. Examples of enhanced dental services may include orthodontics, dental implants, and augmented crown and bridge services beyond Medicaid's limited crown coverage. Examples of CSHCS diagnoses that may qualify for enhanced dental services are listed below. The list is not all inclusive:

- Amelogenesis imperfecta, Dentinogenesis imperfecta
- Anodontia which has significant effect on function
- Cleft palate
- Ectodermal dysplasia, epidermolysis bullosa with significant tooth involvement
- Juvenile periodontitis
- Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to temporomandibular joint arthritic involvement

- Post-operative care related to neoplastic jaw disease
- Severe maxillofacial or craniofacial anomalies that require surgical intervention, including orthognathic surgery
- Traumatic injuries to the dental arches

Most CSHCS enhanced dental benefits require prior authorization. Treatment for enhanced dental services is not authorized beyond age 26. Refer to the Children's Special Health Care Services Dental Benefit section in the Dental chapter for additional information.

To request approval as a CSHCS provider of enhanced dental services, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)

9.2 Care Coordination Benefit

Beneficiaries enrolled in CSHCS with identified needs may be eligible to receive Care Coordination services.

Care Coordination services may be provided by the local health department. LHD staff includes registered nurses (RNs), social workers, or paraprofessionals under the direction and supervision of RNs. Staff must be trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families.

Care Coordination is not reimbursable for beneficiaries also receiving Case Management services during the same LHD billing period, which is usually a calendar quarter. In the event Care Coordination services are no longer appropriate and Case Management services are needed, the change in services may only be made at the beginning of the next billing period.

Families/beneficiaries can contact the LHD for assistance in obtaining Care Coordination services.

9.3 Case Management Benefit

Beneficiaries with either CSHCS, CSHCS and Medicaid, or Medicaid only (no CSHCS) may be eligible to receive Case Management services if they have a CSHCS medically eligible diagnosis, complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. LHDs or approved contractors may provide Case Management services. When there is additional training criteria required to perform a specific Case Management role based upon the service being provided (e.g., Elevated Blood Lead services), the provider of the service must be trained and certified, and services must be performed according to the training and requirements specific to that role. Case Management requires the development of a comprehensive plan of care (POC) which meets the minimum elements, as determined by MDHHS, and is monitored/revised as necessary. All services must relate to objectives/goals documented in the POC.

Case Management services address complex needs and services and include an initial in-person encounter with the beneficiary/family. Case Management requires that services be provided in the home setting or other non-office setting based on family preference. Beneficiaries are eligible for a maximum of six billing units per eligibility year. Services above the maximum of six require prior approval by MDHHS. To request approval, the Case Management provider must submit an exception request, including the rationale for additional services, to MDHHS. Limitations on the need for and number of

Case Management service units are set by MDHHS and must be provided by a specific Case Management role, in accordance with training and certification requirements and as specified by the rules within that service type.

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed by or contracted with a LHD as a Public Health nurse at the entry level or above, or be able to demonstrate to MDHHS that comparable qualifications are met.

Case Management and Care Coordination services within a specific Case Management role cannot be billed during the same LHD billing period, which is usually a fiscal quarter.

Families/beneficiaries can contact the LHD for assistance in obtaining Case Management services.

9.4 Hospice Benefit

The CSHCS hospice benefit provides assistance to a family/beneficiary when end of life care related to the beneficiary's CSHCS qualifying diagnosis is appropriate. Hospice is intended to address the medical needs of the beneficiary with a terminal illness whose life expectancy is limited to six months or less.

Hospice services must be prior authorized. Prior authorization requests require medical documentation from the beneficiary's enrolled CSHCS subspecialist who is authorized (i.e., listed on the beneficiary's CSHCS authorized provider file) to treat the terminal illness. The medical documentation must include all of the following:

- A statement of the terminal diagnosis.
- A statement that the beneficiary has reached the terminal phase of illness where the CSHCS subspecialist deems end of life care necessary and appropriate.
- Documentation of the need to pursue end of life care.
- A statement of limited life expectancy of six months or less.
- A proposed plan of care to address the service needs of the beneficiary that is:
  - less than 30 days old;
  - consistent with the philosophy/intent of the CSHCS hospice benefit as described above;
  - clinically and developmentally appropriate to the beneficiary's needs and abilities;
  - representative of the pattern of care for a beneficiary who has reached the terminal phase of illness; and
  - signed by the CSHCS subspecialist authorized to treat the terminal illness.

The prior authorization time period does not exceed six months. To continue hospice services beyond six months, a new prior authorization request with medical documentation must be submitted as described above.

Hospice may not be authorized and/or continued for a beneficiary when **one or more** of the following is true:

- The medical documentation no longer supports the above criteria (e.g., change in condition, change in the plan of care, etc.).
- The family chooses to discontinue hospice.
- The medical services being rendered by the hospice provider are available through another benefit.

Requests for hospice must be made in writing to CSHCS. (Refer to the Directory Appendix for contact information.) CSHCS responds to all prior authorization requests for hospice services in writing.

9.5 Respite Benefit

Respite services provide limited and temporary relief for families caring for beneficiaries with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, MDHHS must determine the beneficiary to have:

- Health care needs that meet the following criteria:
  - That skilled nursing judgments and interventions be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the beneficiary's care;
  - That the family situation requires respite; and
  - That no other community resources are available for this service.
- No other publicly or privately funded hourly skilled nursing services in the home that would be duplicated by the CSHCS respite benefit.
- Service needs which can reasonably be met only by the CSHCS Respite benefit, not by another service benefit.

Respite is reimbursed when provided by a Medicaid enrolled home health agency, a Medicaid enrolled registered nurse (RN) who is licensed to practice in the state of Michigan, or a Medicaid enrolled licensed practical nurse (LPN) who is licensed to practice in the state of Michigan and working under supervision according to the Michigan Public Health Code. It is the responsibility of the LPN to secure the appropriate supervision and maintain documentation that identifies the supervising professional.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12-month eligibility period. When there is more than one respite-eligible beneficiary in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple beneficiaries. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Beneficiaries receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS Respite benefit:

- Private Duty Nursing Benefit
- Children's Waiver
- Habilitation Supports Waiver
- MI Choice Waiver

Requests for respite must be made in writing to MDHHS (refer to the Directory Appendix for contact information) and include the following information:

- The health care needs of the beneficiary;
- The family situation that influences the need for respite; and
- Other community resources or support systems that are available to the family (e.g., CMH services, MDHHS services, adoption subsidy, SSI, trust funds, etc.).

MDHHS responds to all requests for respite in writing.

9.6 Insurance Premium Payment Benefit

CSHCS may be able to assist in paying the beneficiary's portion of an insurance premium cost (as related to the CSHCS qualifying diagnosis) for private insurance, Medicare Part B, or Medicare Part D. Premium payment assistance may also be available when the beneficiary has lost or is about to lose insurance coverage. Depending on the timing of the event, CSHCS may be able to assist the family in reactivating or maintaining that coverage. The cost-effectiveness requirements described below always apply.

Premium payment assistance may be available when:

- The current cost of the premium payment is determined to be cost-effective for CSHCS. Cost-effectiveness is defined as when the cost of the insurance premium is less than the projected cost to CSHCS for covering the CSHCS-related care; and
- The family/beneficiary lacks sufficient financial resources to pay for the beneficiary's part of the premium. The lack of ability to pay the insurance premium is defined as follows:
  - When the family has an Income Review/Payment Agreement (MSA-0738) that is within the two lowest payment agreement categories, the financial need is automatically established.
  - When the family has an Income Review/Payment Agreement (MSA-0738) that is above the two lowest categories, the family must describe the reason for the lack of resources that is impacting the ability to pay for insurance. Examples include:
    - The additional out-of-pocket expenses to address only the special needs of the beneficiary(ies) is 10% or more of the gross family income. Documentation is required; or
    - The family income has dropped and a revised MSA-0738 still results in a payment agreement that is above the two lowest payment agreement categories but extenuating

financial circumstances interfere with the family's ability to pay insurance premiums, etc. Documentation is required.

To apply for CSHCS insurance premium payment assistance, the following documents are required from all applicants:

- A completed Application for Payment of Health Insurance Premiums (MSA-0725);
- A copy of a billing statement from the insurance carrier or a statement from the employer or Notice of Medicare Premium Payment Due (CMS-500) that verifies the cost of the premium;
- Copies of previous Explanation of Benefits (EOB) statements or expenditure summaries over the past 12 months from the private health insurance carrier or Medicare; and
- A pharmacy report(s) documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare, or written evidence that the coverage does not include a prescription benefit.

The following additional documentation is required under two specific circumstances:

- When the family obtained private insurance through the Federally Facilitated Marketplace (FFM) and has a subsidy, proof is required that the subsidy arrangement is the Advanced Premium Tax Credit. Any other subsidy through the FFM enrollment is not eligible for the insurance premium payment assistance; or
- A Consolidated Omnibus Budget Reconciliation Act (COBRA) Election Form is required if the beneficiary lost insurance coverage within three (3) months before application due to termination of employment, death of the policy holder, divorce, etc., and may be eligible for the insurance to remain in place due to COBRA.

The family/beneficiary may contact the Local Health Department CSHCS office to obtain and receive assistance in completing the MSA-0725.

9.6.A. Effective Date of Insurance Premium Payment Assistance

When premium payment assistance has been approved, the effective date for the coverage is the first day of the month in which the MSA-0725 was received by CSHCS. Insurance premium payments are not covered retroactively for periods before the application was received.

NOTE: Retroactive assistance for premium payment is limited to a one-time-only event when:

- Existing insurance coverage is still active; and
- The private insurance will be terminated due to non-payment; and
- Termination will occur within 30 days of receipt of the MSA-0725 by CSHCS.

The assistance when approved for past coverage is applicable:

- For the beneficiary's portion of the unpaid premium; and
- If those payments will make it possible for the family to pay the remainder of back-payments; and
- When the family can maintain the insurance policy.

9.6.B. Annual Review for Renewal of Eligibility

The MSA-0725 must be submitted each year. The annual eligibility review for continuing premium payment assistance occurs after CSHCS renewal has been completed based on program requirements at that time.

9.6.C. Requirement to Repay CSHCS for Funds Expended on Terminated Policies

In the event that an inappropriate premium payment has been sent to the family (either directly from MDHHS/CSHCS or as a refund to the family by the insurance company), the family is required to return those funds to CSHCS. CSHCS sends the family a letter requesting these funds be submitted to the state. If the funds are not submitted within 60 days from the date on the letter, the Michigan Department of Treasury may collect the funds from the family.

9.7 Children's Multi-Disciplinary Specialty (CMDS) Clinics

Children's Multi-Disciplinary Specialty (CMDS) clinics provide a coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. When a beneficiary has more than one condition that could be served by more than one CMDS clinic, it is required that only one CMDS clinic assumes the care and coordination responsibility for the beneficiary. This will ordinarily be the responsibility of the CMDS clinic that serves the most complex diagnosis. The CMDS clinic fees may only be reimbursed to one of the CMDS clinics if the beneficiary is utilizing the services of more than one CMDS clinic.

CMDS clinic services are reserved for those beneficiaries who have CSHCS and have at least one of the conditions for which CMDS clinics are available. Additional clinic information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.7.A. Explanation of Services

In addition to medical services, CMDS clinics provide:

- A single place and extended appointment for the family to be seen by their team of pediatric specialty providers as well as other appropriate health care professionals during each appointment;
- An environment where providers come to the family for the single appointment at the clinic as opposed to the family needing to set separate dates and times to go to each provider as in the usual service methodology;

- Same day care coordination by all of the providers who saw the beneficiary at each appointment allows for immediate discussion, negotiation, coordination and duty assignment. The family does not need to interpret information from one provider to the next which risks misunderstanding as in the usual service methodology;
- Development and upkeep of a coordinated and comprehensive plan of care (POC) and treatment for beneficiaries, including clear statements of current comprehensive assessment and ongoing treatment plans available to the entire team;
- Facilities that are tailored to the needs of children and their families; and
- Opportunities for the parent/beneficiary to participate in treatment planning, allowing for timely feedback and discussion of concerns with specialists and other health care professionals simultaneously when needed.

Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. CMDS clinic fees are not intended for sporadic users of the services available through CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries who return for and continue to use this full package of services.

9.7.B. CMDS Clinic Staff Requirements

Each CMDS clinic must have the following basic staff available to provide the unique service delivery available through a CMDS clinic model:

Medical Director	A Medicaid-enrolled and CSHCS-approved physician currently licensed to practice under Michigan state law, with special training and demonstrated clinical experience related to the diagnoses followed by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. If the medical director is not a pediatrician, a board certified pediatrician must be available and function within the scope of current medical practice.
Physician	A Medicaid-enrolled and CSHCS-authorized pediatric subspecialist, or adult subspecialist physician when serving adults, currently licensed to practice under Michigan state law with special training and demonstrated clinical experience related to the diagnoses treated by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. Refer to the CMDS Clinic Guide, tables I and II, for subspecialty designations. The CMDS Clinic Guide is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
Registered Nurse	A Registered Nurse (RN) currently licensed to practice under Michigan state law and having a minimum of two years of pediatric nursing experience or adult nursing experience when serving adults. Certain CMDS clinics are exempt from this requirement (e.g., the Metabolic Diseases CMDS clinics) as long as they have the appropriate additional staff as required in the CMDS Clinic Guide.

Registered Dietitian	A Registered Dietitian (RD) in possession of a master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and two years of pediatric nutrition experience or adult nutrition experience when serving adults in providing nutrition assessment, education and counseling.
Social Worker	A Licensed Master Social Worker (LMSW) or professional staff member in possession of a master's degree in social work and two years of experience in counseling and providing service to children/youth, adults and their families.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an actively participating team member in the development of the beneficiary's comprehensive POC.
Additional Required Staff	Additional staffing requirements are based on clinic diagnosis type. Refer to the CMDS Clinic Guides on the MDHHS website for staffing requirements. (Refer to the Directory Appendix for website information.)

9.7.C. CMDS Clinic Visit Types

Beneficiaries with multiple, complex diagnoses may receive CMDS coordinated services from more than one CMDS clinic. However, the limits and numbers of CMDS clinic visit types indicate what the beneficiary is eligible to receive regardless of the number of CMDS clinics the beneficiary is accessing. Any CMDS clinic serving the beneficiary under the CMDS clinic process may submit claims for the appropriate clinic fee(s) up to the limit allowed per beneficiary. For example, there are 10 Support Visits allowed per beneficiary in a year. Any organization/clinic serving the beneficiary may bill for those support visits until the beneficiary limit has been reached. That might involve one CMDS clinic receiving reimbursement for all 10 of the Support Visits or a combination of CMDS clinics receiving reimbursement for some visits until the limit has been reached. The CMDS clinics must document clinic visit levels to include the following:

- Support services must be indicated in the CMDS Plan of Care (POC) developed at a CMDS clinic Comprehensive Initial or Basic Evaluation visit or Management/Follow-up visit.
- The CMDS clinic must collaborate with other CMDS clinics the family/beneficiary may be using regarding which CMDS clinic is the lead CMDS clinic (usually treating the most severe condition) and how the fee billing will occur in coordination between the CMDS clinics that are both serving the same beneficiary.

9.7.C.1. Initial Comprehensive Evaluation

The Initial Comprehensive Evaluation is performed in-person during the CSHCS beneficiary's first visit to the CMDS clinic. The medical team integrates assessments and recommendations and works with the family/beneficiary in the development of a coordinated and comprehensive POC and treatment for the beneficiary. The CMDS POC is required to be recorded. The CMDS clinic will communicate the written CMDS POC to the appropriate health care providers and the family/beneficiary. Written CMDS POCs may be provided to other appropriate health care providers for whom the parent/guardian/beneficiary has signed a medical release form. A copy of the CMDS POC is to be submitted to CSHCS medical consultants for review.

An Initial Comprehensive Evaluation visit must include the following:

- Physician specialist(s) and non-physician professionals examination or assessment of the beneficiary and submission of an established/confirmed diagnosis(es), identification of strengths and needs and, with family/beneficiary input, development of a course of action or plan for treatment;
- Integration of findings and recommendations at team conferences;
- Discussion of the medical findings and treatment recommendations with family/beneficiary in language the family/beneficiary can comprehend;
- Designation of identified staff to teach the family/beneficiary how to assist in the management of the beneficiary's health problems if appropriate; and
- Compilation of an integrated CMDS POC from the findings of the various health care providers that includes:
  - relevant history;
  - medical findings by specialty;
  - problem areas that may develop and for which the beneficiary should receive care;
  - recommendations and prescriptions for braces, shoes, special equipment, medications, etc.;
  - referral to physical therapy, speech-language therapy, occupational therapy, public health nurse, CMDS support services; and
  - a description of how the CMDS POC will be implemented.

Authorization and processes may differ per health plans and Fee-for-Service (FFS).

Reimbursement for the Initial Comprehensive Evaluation fee occurs only once per beneficiary per lifetime regardless of the number of diagnoses and/or CMDS clinics from which the beneficiary may be receiving services. Medical services continue to be billed as usual.

9.7.C.2. Basic and Ongoing Comprehensive Evaluation

Basic and ongoing comprehensive evaluation is conducted with established CMDS patients. The evaluation(s) may include the entire CMDS clinic staff composition or as deemed appropriate by each CMDS clinic Medical Director per visit and is documented in the CMDS POC. At least one visit per year must be conducted in person.

A basic and ongoing comprehensive evaluation may include the following activities:

- Comprehensive beneficiary assessment;
- Evaluation and identification of the beneficiary's needs;
- Coordination of the beneficiary's multi-disciplinary needs;
- Review and modification of the comprehensive CMDS POC;
- Assured implementation and follow-up; and

- Referrals to other professionals, resources, and services as applicable.

Reimbursement for the Basic and Ongoing Comprehensive Evaluation fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility year regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.7.C.3. MANAGEMENT/ FOLLOW-UP VISITS

Management/follow-up visits to a CMDS clinic may be provided if they are recommended in the CMDS POC. In addition, a referral may be recommended based on a tertiary hospital inpatient discharge plan that was written within the previous 12 months of the referral. Every effort should be made to include all staff identified as participants in the CMDS POC or as recommended by the CMDS clinic Medical Director.

The management/follow-up visit may include:

- A physical exam by a pediatrician and/or physician subspecialist(s);
- Assessment by at least two of the clinic staff (in addition to the clinic physicians) designated for the clinic type;
- Follow-up on all components identified in the CMDS POC by appropriate staff;
- Update of condition and treatment, and revision of the CMDS POC; and
- Communication with the family/beneficiary, other providers, and other designated health care providers, including provision of copies of the CMDS POC to the family/beneficiary.

Reimbursement for the management/follow-up visit clinic fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.7.C.4. SUPPORT SERVICE VISITS

CMDS clinics may provide support services. Services consists of counseling, specialized training, transition assistance and/or treatment. Support services must be ordered as part of the CMDS POC developed at a CMDS clinic Initial Comprehensive Evaluation, Basic and Ongoing Comprehensive Evaluation, and/or Management/Follow-up Visit.

CMDS clinic support services may be provided by any combination of one or more of the non-physician basic CMDS clinic staff to the family/beneficiary as outlined in the CMDS POC. Support services may be conducted by professional members of the team (i.e., nurses, dietitians, certified diabetes counselors, social workers or other clinical professional staff as appropriate). The presence of a physician is not required.

- The clinical encounter must be substantive with clinical information gathered, treatment recommendations provided, transition needs addressed and an update to the CMDS POC.
- The clinical content of the encounter is documented in the CMDS POC.

CMDS support service visits include and provide two different methods of delivery:

- Face-to-Face meetings between the appropriate clinic professional and the family/beneficiary; or
- Telephone meetings between the appropriate clinic professional and the family/beneficiary.

Reimbursement for support services clinic fees can be provided up to a maximum of ten (10) visits per beneficiary as a single method or as a combination of methods, per 12-month CSHCS eligibility year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.7.D. Additional Responsibilities

CMDS clinics must establish and maintain an agreement with each Medicaid and MIChild Health Plan for health plan enrolled beneficiaries to ensure coordinated care planning and data sharing.

- CMDS clinics must establish a process for clinical staff to communicate with health plan staff on a regular basis to identify health plan enrollees using the CMDS clinic(s), review testing/assessment/screening results, treatment plans, CMDS POCs, and status of mutually served beneficiaries.
- CMDS clinics must collaborate with health plans on the development of referral procedures and effective means of communicating the need for beneficiary-specific referrals. For beneficiaries enrolled in a health plan, CMDS clinics must bill the Medicaid Health Plan (MHP) for medical services rendered according to the health plan billing rules.

The CMDS clinic fee is billed as a FFS claim through CHAMPS regardless of health plan status. CMDS clinic fees are not intended for sporadic users of the services available through the CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries that return for and continue to use the full package of services.

CMDS clinic fees must be billed according to instructions contained in the Billing & Reimbursement for Professionals Chapter of this Manual. CMDS clinics must bill clinic fees following Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ASC X12N version 5010 information. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing and referring providers as applicable for payment.

SECTION 10 – OUT-OF-STATE MEDICAL CARE

CSHCS covers out-of-state **emergency** medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the beneficiary;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Non-emergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care stated above. Out-of-state non-emergency medical care is covered only when the service has been prior authorized by MDHHS. Prior authorization requests for out-of-state services may be approved when all of the following criteria are met:

- The requested service is related to the CSHCS qualifying diagnosis;
- The request for out-of-state referral is submitted by the appropriate, CSHCS-authorized in-state subspecialist with whom the beneficiary will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state;
- The in-state subspecialist and the out-of-state specialist maintain a collaborative relationship with regard to determining, coordinating, and providing the beneficiary's medical care, including a plan to transition the beneficiary back to in-state services as appropriate;
- Comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis cannot be provided within the State of Michigan;
- The requested service is accepted within the context of current medical standards of care as determined by MDHHS;
- The service has been determined medically necessary by MDHHS because the beneficiary's health would be endangered if they were required to travel back to Michigan for services, if applicable.

All out-of-state providers must complete the Community Health Automated Medicaid Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to MDHHS.

Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDHHS. (Refer to the General Information for Providers Chapter of this manual for additional information.)

The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state. Refer to the Non-Emergency Medical Transportation (NEMT) Assistance section of this chapter for specific information.

SECTION 11 – NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ASSISTANCE

CSHCS may reimburse for travel to assist beneficiaries in accessing and obtaining authorized specialty medical care and treatment (in-state and out-of-state, as appropriate) when the family's resources for the necessary travel pose a barrier to receiving care. NEMT assistance is allowed for the beneficiary and one adult to accompany the beneficiary when the beneficiary:

- Is a minor, or
- Has a court-appointed guardian, and/or
- Has a medical condition that supports the need for a caregiver.

The treatment must be related to the qualifying medical condition and provided by a CSHCS approved provider. The NEMT benefit is not intended to assume the entire cost for the expenses incurred.

11.1 IN-AND OUT-OF-STATE TRAVEL

Requests for NEMT assistance must be made as follows:

- Beneficiaries who are not covered by Medicaid must request NEMT assistance through the LHD.
- Beneficiaries who have Fee-For-Service Medicaid and live in Wayne, Oakland or Macomb County must request NEMT assistance from the contracted transportation broker.
- Beneficiaries who have Fee-For-Service Medicaid and live outside of Wayne, Oakland or Macomb County must request NEMT assistance from their local MDHHS office. When NEMT assistance from the local MDHHS office is unavailable, beneficiaries can request NEMT assistance through the LHD.
- Beneficiaries who are Medicaid Health Plan (MHP) members must request NEMT from their health plan. MHPs may have different prior authorization and documentation requirements from those described in this chapter.

To be eligible and authorized for CSHCS NEMT travel assistance, the beneficiary must be determined by MDHHS to meet the following criteria:

- The beneficiary has CSHCS coverage at the time of the travel;
  - NEMT assistance may be authorized for individuals who do not have CSHCS but need NEMT assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility.
  - There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation.
- The NEMT assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible condition;
- The family/beneficiary lacks the financial resources to pay for all or part of the travel expenses;
- Other travel/financial resources are unavailable or insufficient;
- The mode of travel to be used is the least expensive and most appropriate mode available; and

- Prior approval for NEMT assistance has been obtained.

The following are additional criteria for out-of-state NEMT assistance:

- Comparable medical care is not available to the beneficiary within the state of Michigan or borderland areas.
- Prior approval for the out-of-state medical care and treatment was obtained from MDHHS before NEMT assistance was requested.

Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

11.2 NEMT Reimbursement Process

In-state NEMT assistance for beneficiaries who do not have Medicaid, or who are receiving non-Medicaid eligible services, does not require prior authorization. Out-of-state NEMT assistance requests may be initiated by the LHD and must be authorized by the CSHCS state office. Prior authorization may be issued up to one calendar month for recurring visits.

Reimbursement is made according to the allowable amount established by MDHHS. Rates are reviewed at least annually and published on the MDHHS website. (Refer to the Directory Appendix for website information.)

Reimbursement for beneficiaries with Medicaid coverage who request NEMT assistance from their local MDHHS office is provided in accordance with the Medicaid/MDHHS Non-Emergency Medical Transportation policy.

Beneficiaries who are authorized for CSHCS NEMT assistance must request reimbursement by submitting the completed Client Transportation Authorization and Invoice form (MSA-0636) and Addendum according to the General Instructions. Receipts are required for all reimbursable expenditures except mileage. Meal expenditures are not reimbursable. Requests for NEMT reimbursement must be received by MDHHS within 90 days following the authorized month of travel to be considered for payment. New enrollees may be reimbursed retroactive to the date of CSHCS enrollment when applicable.

Ground Transportation	▪ Mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDHHS. ▪ Car rentals, parking costs, and highway, bridge, and tunnel tolls require receipts. ▪ Bus, taxi, ferry or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by receipts.
Air Travel	▪ The family cannot be reimbursed for airline tickets unless prior approval to purchase the tickets was obtained from MDHHS/CSHCS. Receipts are required for reimbursement. ▪ Baggage charges, etc. require receipts.

Lodging	▪ The beneficiary must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered condition, performed by a CSHCS approved provider and at a CSHCS approved medical facility, in order for the family to be reimbursed for lodging. ▪ Inpatient Requirements: Reimbursement is for the accompanying adult as needed. ▪ Outpatient Requirements: Reimbursement is for the beneficiary and the accompanying adult as needed. ▪ MDHHS reimburses lodging up to the allowable amount established by MDHHS, regardless of cost. Receipts are required.

11.3 Commercial or Non-profit Transportation Provider (Non-ambulance)

Beneficiaries may be eligible for NEMT through a commercial or non-profit provider (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or public entities, etc.) when at least one of the following conditions is met. Beneficiary is:

- Wheelchair dependent; or
- Bed bound; or
- Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation; or
- Unable to access public or private transportation for the purpose of obtaining medical care.

CSHCS NEMT provided by a commercial or non-profit transportation provider must be prior approved by the LHD on the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709). Payment is made directly to the commercial or non-profit transportation provider by MDHHS. The family/beneficiary should not pay the provider directly since the family/beneficiary cannot be reimbursed.

11.4 Emergency and Special Transportation Coverage

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying condition. (Refer to the Ambulance Chapter of this manual for additional information.)

An additional person, such as a donor related to the medical care of the beneficiary, may be considered for NEMT assistance when approved by a MDHHS medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the beneficiary and the additional person.

SECTION 12 – CSHCS COORDINATION WITH OTHER HEALTH CARE COVERAGE

Beneficiaries may have coverage through CSHCS and another program simultaneously.

12.1 MEDICAID

Beneficiaries may have both Medicaid and CSHCS coverage. The beneficiary must comply with Medicaid requirements.

12.2 MICHILD

Beneficiaries may have both MIChild and CSHCS coverage. The beneficiary must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.

12.3 TRANSITIONAL MEDICAL ASSISTANCE (TMA)

Beneficiaries may have both TMA and CSHCS coverage. For services not covered by CSHCS and covered by TMA, the beneficiary must comply with TMA requirements.

12.4 MATERNITY OUTPATIENT MEDICAL SERVICES

Beneficiaries may have both MOMS and CSHCS coverage. The beneficiary must comply with MOMS requirements.

12.5 COURT-ORDERED MEDICAL INSURANCE

CSHCS cannot be used as court-ordered medical insurance.

12.6 MEDICARE

Beneficiaries may have both Medicare and CSHCS. The beneficiary must comply with Medicare requirements.

CSHCS may cover the out-of-pocket pharmacy costs related to the CSHCS covered diagnoses for CSHCS beneficiaries enrolled with a Medicare Part D Pharmacy Drug Plan. These out-of-pocket costs include copays, co-insurance and deductibles specific to the Medicare Part D pharmacy benefit. Providers and beneficiaries should contact CSHCS for additional information regarding the reimbursement of out-of-pocket pharmacy costs. (Refer to the Directory Appendix for contact information.)

12.7 HEALTHY MICHIGAN PLAN

Beneficiaries may have both the Healthy Michigan Plan and CSHCS. The beneficiary must comply with the Healthy Michigan Plan requirements.

SECTION 13 – APPEALS

13.1 DEPARTMENT REVIEWS

Beneficiaries without Medicaid coverage are entitled to appeal MDHHS negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed, or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDHHS for all MDHHS programs.

13.2 ADMINISTRATIVE HEARINGS

Beneficiaries who also have Medicaid coverage have a right to an administrative hearing when services have been denied, reduced, changed or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. The beneficiary may receive an administrative hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The beneficiary may receive a department review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The Michigan Office of Administrative Hearings and Rules (MOAHR) determines which hearing is appropriate once a beneficiary has requested a hearing.

CHIROPRACTOR

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Chiropractors.

1.1 MEDICAL NECESSITY

Determination of medical necessity and appropriateness of service is the responsibility of chiropractors within the scope of accepted medical practice and Medicaid limitations. Chiropractors are held responsible if excessive or unnecessary services are ordered, regardless of who actually renders these services (e.g., x-rays), or if reimbursement is received for the service. Chiropractors are subject to any corrective action related to these services, including recovery of funds.

1.2 BENEFICIARY COPAYMENT

A copayment for each Medicaid reimbursable chiropractic visit may be required for beneficiaries age 21 years and older. (Refer to the General Information for Providers Chapter for information about copayments.) Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single copayment may be charged to the beneficiary.

When billing Medicaid for the service, chiropractors should bill their usual and customary (U&C) charge (i.e., without any adjustment for the copayment). Upon approval of the service, Michigan Department of Health and Human Services (MDHHS) automatically deducts the copayment. If the chiropractor deducts the copayment from the charge billed, an underpayment may result.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.3 OTHER INSURANCE AND MEDICARE SERVICES

It is the chiropractor's responsibility to question the beneficiary regarding Medicare and other insurance coverage prior to providing the service. Medicaid is the payer of last resort. Payment must be sought from other third party payers before submitting claims to MDHHS. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.4 NURSING FACILITY

Chiropractors may render manual spinal manipulations to beneficiaries in a NF as an ancillary service. The attending physician (MD or DO) must order all ancillary services, including chiropractic services. The chiropractor must keep and make available complete records of the services provided.

SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays.

Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation.

If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary.

Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis, including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and
- Include any additional details, comments, etc. that may be of assistance in the evaluation.

The PA request is reviewed and a notice is returned to the provider stating the approval or denial of the request. If approved, the provider is notified of the number of additional visits granted. Providers are also given a PA number that must be placed in the PA field on the claim form when billing for the additional services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for claim completion instructions.)

2.3 X-Ray Services

A chiropractor may order, and be reimbursed for, no more than one set of spinal x-rays per beneficiary, per year. If more than two procedures are provided for the beneficiary on the same date of service, the services must be combined and billed as one inclusive procedure code, such as the entire radiologic examination of the spine with survey study, anteroposterior and lateral.

SECTION 3 – CODES

3.1 DIAGNOSIS CODES

Chiropractors must use at least one diagnosis code in conjunction with the procedure codes when billing chiropractic services. MDHHS follows the Medicare diagnosis coding requirements for chiropractic services.

3.2 PROCEDURE CODES

Chiropractors must use at least one appropriate procedure code from the Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) coding manuals. A list of procedure codes covered by MDHHS is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 4 – NONCOVERED SERVICES

Chiropractic services excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:

- Consultations
- Fracture care
- Home visits
- Injections
- Laboratory tests
- Maintenance therapy
- Medical supplies
- Evaluation and management services
- Plaster casts
- Inpatient hospital visits

COMMUNITY HEALTH WORKER SERVICES

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SECTION 1 – INTRODUCTION

1.1 GENERAL INFORMATION

A Community Health Worker (CHW)/community health representative (CHR) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between the health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. The CHW/CHR is a non-licensed public health provider who facilitates access to needed health and social services for beneficiaries. Hereafter, the term CHW will be used to represent both CHW and CHR terminology.

CHW services focus on preventing disease, disability, and other chronic health conditions or their progression, and promoting physical and mental health. These services are designed to be person-centered and patient driven, with a focus on beneficiary empowerment, fostering self-advocacy skills to promote personalized and effective diagnosis or treatment.

1.2 BENEFICIARY NEED AND RECOMMENDATION OF SERVICES

Conditions that may define a beneficiary's need for CHW services must be assessed utilizing an appropriate health risk and/or social determinant of health (SDOH) screening/assessment tool. The conditions that may support the need for the CHW services include, but are not limited to:

- Diagnosis of one or more chronic health conditions, including behavioral health;
- Unmet health-related social need; or
- Pregnancy and up to 12 months postpartum.

As required by federal regulations at CFR 440.130(c), CHW services must be recommended by a licensed health care provider. Health care providers qualified to recommend CHW services include, but are not limited to, the following:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse
- Registered Nurse
- Licensed Master Social Worker
- Dentist
- Psychiatrist or Psychologist

Licensed health care providers recommending CHW services are not required to be part of the beneficiary's health care team, but collaboration is highly encouraged.

SECTION 2 – COVERED SERVICES

CHW services must be provided face-to-face. CHW services should be provided in the language of the beneficiary's choice when possible. Refer to the Glossary Appendix of the MDHHS Medicaid Provider Manual for the definition of "face-to-face."

CHW services available to beneficiaries include health system navigation and resource coordination, health promotion and education, and screening and assessment.

2.1 HEALTH SYSTEM NAVIGATION AND RESOURCE COORDINATION

Health system navigation and resource coordination include providing information, training, referrals, or support to encourage beneficiary-led efforts to access covered services, understand, engage, or re-engage in the health care system, or engage in their own care needs.

These services also work to connect beneficiaries to relevant community resources necessary to promote health, address health care barriers, or address health-related social needs.

The following are examples of health system navigation and resource coordination:

- Helping to engage, re-engage, or ensure beneficiary-led follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions.
- Helping a beneficiary find the appropriate Medicaid provider to receive a recommended covered service.
- Helping a beneficiary make and keep an appointment for a Medicaid covered service.
- Helping a beneficiary find and access other relevant community resources.
- Helping a beneficiary with a telehealth appointment and/or educating a beneficiary on the use of telehealth technology.
- Connecting a beneficiary to medical translation/interpretation or transportation services.
- Serving as a cultural liaison or assisting a licensed health care provider to create a plan of care, as part of the health care team.

2.2 HEALTH PROMOTION AND EDUCATION

Health promotion and education includes services that promote the beneficiary's health or address barriers to physical and mental health care, including providing information, instruction, methods, and measures on health topics that have been proven effective in preventing disease, disability, and other health conditions or their progression; prolonging life; and/or promoting physical and mental health and efficiency. The content of health promotion and education must be consistent with established or recognized health care standards and best practices. Health promotion and education may include coaching and goal-setting to improve a beneficiary's health or ability to self-manage health conditions.

The following are examples of Health Promotion and Education topics:

- Addressing family violence/inter-partner violence
- Control of certain health conditions (i.e., heart disease, high blood pressure, dental disease, etc.)

- Diabetes prevention and control
- Chronic disease self-management
- Chronic pain self-management
- Sexual and reproductive health
- Improvement in safety and the environmental health of housing (i.e., to mitigate asthma risk, risk of injury from unsafe housing, lead exposure, etc.)
- Improvement in nutrition, physical and/or mental health
- Promotion of preventative services, such as cancer screenings and immunizations
- Reduction in the misuse of alcohol or drugs
- Stress management and reduction

2.3 Screening and Assessment

Screening and assessment services include the use of standardized, validated tools that do not require a license and that support the identification of needed services and supports.

2.4 Documentation of Services

Documentation must include date of service, a start and end time of services provided, a description of the professional services rendered, and information regarding the source of the licensed health care provider's recommendation for services. Documentation must be kept in accordance with the record keeping requirements of the Medicaid program and may be subject to review and post-payment audit. (Refer to the Record Keeping section within the General Information for Providers chapter of the MDHHS Medicaid Provider Manual for more information.)

SECTION 3 – NON-COVERED SERVICES

CHW Services cannot duplicate services that are covered under the existing Medicaid State Plan. The following services, while important in various contexts, are not reimbursable under the CHW Services policy and associated billing codes. These services include, but are not limited to:

- Clinical case/care management that requires a license
- Community Transition Services
- Companion services
- Discharge planning
- Delivery of medication, medical equipment, or medical supply
- Employment services
- Helping a beneficiary enroll in government or other assistance programs that are not related to improving their health as part of a provider's recommendation
- Personal care services/Home Help, including shopping and cooking meals
- Respite care
- Services that require a license
- Support services covered under behavioral health services programs by Certified Peer Support Specialists (CPSS) or Certified Peer Recovery Coaches (CPRC)
- Transporting beneficiaries

SECTION 4 – CHW QUALIFICATIONS CRITERIA

This section describes the minimum requirements needed of an individual delivering CHW services to meet the criteria necessary to be verified by the MDHHS designated contractor before the Community Health Automated Medicaid Processing System (CHAMPS) enrollment for Michigan Medicaid reimbursement. Individuals may meet the qualifications criteria and be recognized as certified CHWs through either the CHW Training Program Pathway or the Work Experience Pathway. Refer to the Directory Appendix for website information.

Individuals who meet the verification requirements through the MDHHS designated contractor will be registered with the contractor as certified CHWs and included in the MI Medicaid CHW Registry. (Refer to the Directory Appendix for additional information.) Individuals seeking to deliver CHW services to Medicaid beneficiaries must be registered with the MDHHS contractor prior to enrolling as a Medicaid provider. Additional details regarding the contractor's CHW registry and application process will be made available to all interested parties.

To qualify to deliver Medicaid reimbursable CHW services, an individual must meet the following criteria:

- Must be 18 years of age or older;
- Possess at least a high school diploma or high school equivalency diploma/certification;
- Must meet the CHW Training Program Pathway or the Work Experience Pathway;
- Has successfully completed a CHW application with the MDHHS designated contractor and must be listed in good standing on the MI Medicaid CHW Registry; and
- Complete provider enrollment requirements detailed in the Provider Enrollment section of this policy (below).

CHW Training Program Pathway	To be recognized as a MI Medicaid certified CHW under the CHW Training Program Pathway, an individual must have completed an MDHHS-approved Community Health Worker training program that aligns with the Community Health Worker Core Consensus Project (C3 Project) core competencies. (Refer to the Directory Appendix for additional information.)
Work Experience Pathway	During the initial 24 months of the policy implementation (from January 1, 2024, to December 31, 2025), an individual who does not possess the CHW Training Program Pathway qualifications will be permitted to temporarily deliver CHW services and seek reimbursement if the individual meets the following criteria: ▪ Has completed 1,000 hours of experiential learning in the previous three years; and ▪ Has a plan for completing a CHW training program, as described above. A CHW certified through the Work Experience Pathway must complete their MDHHS-approved CHW training program by December 31, 2025, to maintain their eligibility to continue delivery of CHW services for Medicaid reimbursement.

All CHWs are required to maintain a minimum of six (6) hours of continuing education through an MDHHS-approved CHW training program annually that aligns with the C3 Project core competencies. Appropriate documentation must be provided to the MDHHS designated contractor to remain in good standing on the MI Medicaid CHW Registry.

SECTION 5 – PROVIDER ENROLLMENT

After verification of qualifications by the MDHHS designated contractor, certified CHWs seeking reimbursement for services to Medicaid beneficiaries are required to be Medicaid-enrolled providers. To enroll as a Medicaid provider, a certified CHW must complete an online application in CHAMPS and must enroll with an Individual (Type 1) National Provider Identifier (NPI) as a Rendering/Servicing-Only Provider. As part of the enrollment process, certified CHWs must associate themselves to at least one Medicaid-enrolled billing provider within CHAMPS. The billing provider must have a Group/Organizational (Type 2) NPI **or** be an Individual Sole Proprietor with an Individual (Type 1) NPI. Associated billing providers may be employers or organizations the CHW is contracted with to perform services.

Rendering/Servicing CHAMPS enrollment instructions can be found on the MDHHS Provider Enrollment page. (Refer to the Directory Appendix for additional information.)

Individuals delivering CHW services to Medicaid beneficiaries are subject to all relevant policy provisions outlined in the MDHHS Medicaid Provider Manual, including the General Information for Providers Chapter.

SECTION 6 – REIMBURSEMENT

6.1 REIMBURSEMENT CONSIDERATIONS AND BILLING GUIDELINES

CHW services are to be reported as follows:

- 98960 (education and training for patient self-management; individual patient)
- 98961 (education and training for patient self-management; 2-4 patients)
- 98962 (education and training for patient self-management; 5-8 patients)

Medicaid-enrolled groups/organizations billing for CHW services must report the enrolled CHW as the rendering/servicing provider within the appropriate field on the claim. The CHW reported as the rendering/servicing provider must be enrolled in CHAMPS on the date of service reported on the claim.

For CHW services rendered to beneficiaries enrolled in a Medicaid Health Plan (MHP) or Integrated Care Organization (ICO), providers will submit claims to the beneficiary's assigned MHP or ICO. If a beneficiary is not enrolled in an MHP or ICO, CHW providers will submit claims for Fee for Service (FFS) reimbursement through CHAMPS.

For additional CHW services billing information, refer to the Billing & Reimbursement for Professionals chapter.

6.2 SERVICE LIMITATIONS AND PRIOR AUTHORIZATION

CHW services are limited to two hours (eight units) per day and 16 visits per month, for a maximum of 32 hours (128 units) per month, per beneficiary. This limit may be exceeded based on medical necessity determined in collaboration with the recommending licensed provider and requires prior authorization. Group services are limited to eight unique beneficiaries at one time. There are no Place of Service (POS) restrictions for CHW services.

6.3 FQHC, RHC, THC AND TRIBAL FQHC REIMBURSEMENT

The following information applies to clinics billing on behalf of CHWs for services provided within the facilities. Services provided by CHWs do not count as a qualifying visit. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Tribal Health Centers (THCs), and Tribal FQHCs furnishing eligible CHW services will be reimbursed outside of the Prospective Payment System (PPS) methodology or All-Inclusive Rate (AIR) methodology at the applicable Medicaid fee screen rates.

CHW services billed by clinics should be billed on the institutional claim form using the Group/ Organizational - Type 2 clinic specialty enrolled NPI. On the institutional claim form, the Attending Provider field line should include an eligible Individual – Type 1 provider. This is the provider responsible for the overall care of the beneficiary at the clinic. Finally, the Individual – Type 1 NPI of the CHW rendering the actual service to the Medicaid beneficiary at the clinic should be listed in the Other/Rendering field line (referring/rendering/ordering).

Procedure code coverage information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.4 Health Homes

A CHW can serve as a member of the Health Home Care Team (HHCT) as well as be a staff member of the FQHC/Designated Health Home Partner. (Refer to the Directory Appendix for additional information.) The goal of this policy is for CHWs and Health Homes to complement each other and work together for the benefit of the beneficiary. If Medicaid is billed for CHW services and the Health Home is claiming a core service for a month, it is important that the services are separate and distinct. CHW services may not be duplicative of the monthly core services being claimed by a Health Home.

6.5 Certified Community Behavioral Health Clinic (CCBHC)

A CHW can serve as part of the CCBHC demonstration staffing structure and associated costs can be included in the PPS rate. If CHW costs are included in a CCBHC's PPS rate, the CCBHC shall not seek additional Medicaid reimbursement for CCBHC-related activities provided by the CHW. Additionally, when CHW costs are included in the PPS rate, CCBHCs must ensure that CHWs operate within requirements of the CHW policy.

6.6 Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs)

MHPs and ICOs who employ CHWs are obligated to adhere to their contractual requirements for CHW certification, enrollment, and services, and may not seek additional reimbursement.

SECTION 7 – SPECIALTY BEHAVIORAL HEALTH PROVIDERS

CHW covered services (outlined in the Covered Services section of this chapter) are included in the Behavioral Health Code Charts and reimbursable through Prepaid Inpatient Health Plans (PIHPs) effective for dates of service on or after October 1, 2024.

7.1 GENERAL INFORMATION

CHWs have an important role promoting health outcomes related to both physical and behavioral health. CHWs can be utilized by specialty behavioral health providers to facilitate access to needed health and social services.

7.2 COVERED SERVICES

Covered services are the same as outlined in the Covered Services section of this chapter.

Peer Support Specialist (PSS) and Peer Recovery Coach (PRC) services are separately covered. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information. To seek Medicaid reimbursement for the delivery of CHW services, an individual must meet the requirements outlined in the CHW Qualifications Criteria section of this chapter.

COMMUNITY TRANSITION SERVICES

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SECTION 1 – GENERAL INFORMATION

Community Transition Services (CTS) are Home and Community-Based Services (HCBS) for Medicaid beneficiaries who meet eligibility criteria. The benefit is administered by the Michigan Department of Health and Human Services (MDHHS) on a fee-for-service (FFS) basis through transition agencies including Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations.

Beneficiaries eligible for CTS include nursing facility and institutional residents who meet needs-based criteria and have at least one risk factor as described in this chapter. Provision of CTS does not relieve institutions of required discharge planning activities.

1.1 DEFINITION OF TERMS

Community Health Automated Medicaid Processing System (CHAMPS)	The MDHHS web-based Medicaid claims and enrollment processing system.
Compass	Web-based information system utilized for tracking beneficiary data.
Michigan Department of Licensing and Regulatory Affairs (LARA)	The State of Michigan agency responsible for professional licensing.

SECTION 2 – BENEFICIARY ELIGIBILITY FOR COMMUNITY TRANSITION SERVICES [CHANGE MADE 4/1/2025]

To be eligible for CTS, beneficiaries must:

- be eligible for Medicaid or have **all** the following:
  - a completed Michigan Medicaid application with all necessary verifications submitted to the local MDHHS office awaiting review;
  - reasonable assurance that local MDHHS office will likely approve the submitted application; and
  - application registration on Bridges as verified by MDHHS.
- be age 65 or older;
- be age 18 through 64 with a physical disability;
- meet one of the following:
  - be at risk of inappropriate institutionalization due to being served in an institution but do not meet the level of care for that institution;
  - indicate on the Freedom of Choice form that they no longer choose to receive long term services and supports in an institutional setting; or
  - the beneficiary does not currently reside in a nursing facility or other institution but is at risk of returning to the nursing facility without the provision of CTS. **(text added per bulletin MMP 24-49)**
- meet Needs-Based Criteria identified within this chapter; and
- have at least one risk factor, as identified within this chapter, that cannot be addressed by standard institutional discharge procedures.

2.1 NEEDS-BASED CRITERIA

Beneficiaries must be assessed to minimally meet Needs-Based Criteria under Door A, B, or C.

Door A: Activities of Daily Living (ADLs)	The beneficiary requires assistance to perform at least one ADL or instrumental activity of daily living (IADLs). ADLs include bed mobility, transfers, toilet use, eating, dressing, personal hygiene, bathing, and locomotion. IADLs include shopping, cooking, managing medications, using the phone, housework, laundry, public transportation, or managing finances.
Door B: Cognitive Performance	The beneficiary: ▪ needs minimal assistance in making safe decisions in familiar situations, but experiences some difficulty in decision-making when faced with new tasks or situations due to a short-term memory problem; ▪ is assessed with some difficulty making decisions in new situations or makes poor or unsafe decisions in recurring situations; or

	▪ is assessed to be usually understood and needs assistance (i.e., little or no prompting) finding the right words or finishing thoughts due to a short-term memory problem.
Door C: Behavior	The beneficiary is assessed to have required assistance managing one of the following challenging behaviors in the last seven (7) days: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, or resisted care.

2.2 Risk Factors

Beneficiaries must have at least one of the following risk factors:

- history or at risk of inability to secure or retain housing in the community;
- history or at risk of inability to secure HCBS without assistance;
- history or at risk of inability to secure documentation needed for independent living without assistance, including identification cards, health insurance cards, birth certificate, etc.; or
- history of an unsafe or inaccessible living environment.

2.3 Re-Evaluation of Eligibility

Individuals who have been approved to receive CTS must have an annual re-evaluation of their eligibility. This includes a re-evaluation of eligibility criteria mentioned above as well as a re-assessment using the community transition assessment.

SECTION 3 – COVERED SERVICES [CHANGE MADE 4/1/2025]

To qualify for CTS, beneficiaries must receive monthly monitoring and at least one of the transition services outlined in the Transition Navigation Case Management subsection of this chapter every three months. Transition services are not available through a self-directed arrangement. **(revised per bulletin MMP 24-49)**

3.1 TRANSITION NAVIGATION CASE MANAGEMENT

Transition Navigator (TN) services are provided to ensure the delivery of supports and services needed to meet the beneficiary's goals for living in the community after an institutionalization. The TN functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's person-centered service plan (PCSP). The frequency and scope of TN contacts must take into consideration the health and welfare needs of the beneficiary. TN services may include the direct provision of CTS as specified in the PCSP.

Functions performed by the TN include:

- Conducting the initial and subsequent needs-based criteria evaluation and community transition assessment, and providing that evaluation to MDHHS for approval.
- Annual reassessment and re-evaluation of Medicaid eligibility.
- Gathering, reviewing, documenting, and updating information relating to the assessment and beneficiary's history (i.e., medical, social, etc.).
- Supporting a person-centered planning (PCP) process that:
  - focuses on the beneficiary's preferences;
  - includes family and other allies as determined by the beneficiary;
  - identifies the beneficiary's goals, preferences and needs;
  - provides information about options; and
  - focuses on engaging the beneficiary in monitoring and evaluating services and supports.
- Developing a PCSP using the PCP process, including revisions to the plan at the beneficiary's request or as changes in the beneficiary's circumstances may warrant.
- Conducting the PCP meeting.
- Completing the PCSP.
- Referral to and coordination with providers of home and community-based services and supports, including non-Medicaid services and informal supports. This may include helping with access to entitlements or legal representation.
- Monitoring of the services and supports identified in the PCSP for achievement of the beneficiary's goals. Monitoring includes opportunities for the beneficiary to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the beneficiary and other key sources of information as determined by the beneficiary.

- Providing social and emotional support to the beneficiary and allies to facilitate life adjustments and reinforce the beneficiary's sources of support. This may include arranging services to meet those needs.
- Providing advocacy in support of the beneficiary's access to benefits, ensuring the beneficiary's rights as a Medicaid beneficiary, and supporting the beneficiary's decisions.
- Monitoring the beneficiary after the community transition to ensure a successful adjustment to community life, including ensuring access to and enrollment in needed HCBS programs.
- Maintaining documentation of the above listed activities to ensure successful support of the beneficiary, compliance with Medicaid and other relevant policies, and meeting quality assurance and quality improvement requirements.
- Conducting a tenant screening and housing assessment that identifies the beneficiary's preferences and barriers related to successful tenancy. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers.
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the beneficiary's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required to meet the goal.
- Assisting with the housing search and application process.
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses.
- Completing documentation needed to secure services.
- Ensuring that the living environment is safe and ready for move-in.
- Assisting in, arranging for, and supporting the details of the move.
- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Education and training on the roles, rights, and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords and property managers with a goal of fostering successful tenancy.
- Assistance in resolving disputes with landlords and neighbors to reduce risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
- Assistance with the housing recertification process.
- Coordinating with the beneficiary to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.

- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management.
- If risks are identified during the PCP process, discuss with the beneficiary any strategies to mitigate those risks.

3.1.A. Transition Navigator Provider Qualifications

Provider Type	License or Other Standard	Verification (Annual)
Registered Nurse (RN)	RN, licensed in Michigan	LARA, CHAMPS
Social Worker	Limited or full license: Limited License Bachelor of Social Work (LLBSW), Limited License Master of Social Work (LLMSW), Licensed Baccalaureate Social Worker (LBSW), or Licensed Master Social Worker (LMSW), licensed in Michigan	LARA, CHAMPS
Other Transition Navigator	Non-licensed or other licensed health care professional with the following qualifications: ▪ a bachelor's degree in a health or human services field or Community Health Worker certification, and ▪ at least three years of experience in the provision of health or social services. If licensed, must be licensed in Michigan.	CHAMPS

3.2 Community Transition Services [Change Made 4/1/2025]

CTS are non-reoccurring expenses necessary to enable a beneficiary who is transitioning from a nursing facility or other institutional setting to the community to establish a basic household and do not constitute room and board. This service is available while in the institution to prepare the beneficiary's chosen home and to accommodate a successful discharge to the community. This service may be available in the community when additional needs that were not accounted for prior to discharge are identified.

CTS includes the following:

- Security deposits and fees for community living, **(revised per bulletin MMP 24-49)**
- Set-up fees for utilities or service access, including telephone, electricity, heating and water,
- Essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens, and
- Services necessary for the beneficiary's health and safety, such as pest eradication, allergen control, and one-time cleaning prior to occupancy.

Some items or services under CTS may require prior authorization from MDHHS. (Refer to the Directory Appendix for website information related to the Transition Services Coding Structure.)

3.2.A. Limitations

CTS are furnished only to the extent that they are reasonable and necessary as determined through the PCSP development process, clearly identified in the PCSP and only when the beneficiary is unable to meet such expense, or when the services cannot be obtained from other sources. CTS do not include monthly rental or mortgage expenses, food, regular utility charges, or household appliances or items that are intended for purely diversional or recreational purposes.

Personal emergency response systems provided as a transition service are limited to those that do not have ongoing monthly fees and are a one-time purchase.

3.2.B. Provider Qualifications

Provider Type	License or Other Standard	Verification	Frequency of Verification
Center for Independent Living	Enrolled as Medicaid Provider in CHAMPS	LARA, CHAMPS	Annually
Area Agency on Aging	Enrolled as Medicaid Provider in CHAMPS	LARA, CHAMPS	Annually
Community Based Organization	Enrolled as Medicaid Provider in CHAMPS	CHAMPS	Annually
Retail Stores	Items purchased from retail stores must meet the CTS definition.	Transition Agency	Prior to furnishing services and annually thereafter.
Contractor, Builder	Licensed Contractor or Builder. Licensed in Michigan	LARA	Annually

3.3 Non-Medical (Non-Emergency) Transportation

Non-Medical (Non-Emergency) Transportation (NMNET) is offered to enable beneficiaries to gain access to community services, activities and resources specified by the beneficiary's PCSP.

NMNET services may be provided while in the community to address issues identified on the PCSP. This may include, but is not limited to, going to the grocery store, religious services, volunteering, or work.

This service is available while in the institution, though limited to visiting potential community-based residences and travel to businesses or agencies to address barriers to community-based living. Examples of transportation to a business or agency to address a barrier would be to go to the bank to open an account, or the local Secretary of State office to obtain a State Identification Card.

The fee schedule established by MDHHS for the Non-Emergency Medical Transportation (NEMT) service must be utilized for this NMNET service. Transition agencies may request prior authorization for reimbursement rates that are higher than the NEMT rates.

3.3.A. Limitations

Whenever possible, family, neighbors, friends or community agencies that can provide transportation without charge must be utilized before authorizing this transition service. NMNET services offered are not available through the State Plan and are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a). This service does not include purchasing, leasing, repair or maintenance of vehicles.

This service may not be authorized to reimburse caregivers to run errands for beneficiaries when the beneficiary does not accompany the driver of the vehicle. The purpose of this service is to enable the beneficiary to gain access to their community services, activities, and resources.

Reimbursement does not include expenses for meals or lodging incurred while traveling.

3.3.B. Provider Qualifications

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual (paid or volunteer, no familial relationship)	Must have Michigan Driver's License and be enrolled in CHAMPS. All drivers must have vehicle insurance as required by the State of Michigan. All drivers must follow all motor vehicle laws. All passengers must comply with seat belt laws.	Transition Agency	Annually
		Secretary of State	Every 4 years (renewal of Driver's License)
Public Transit	Must have Michigan Driver's License. Must follow all applicable laws, including licensure, inspections, vehicle maintenance, etc.	Secretary of State	Annually
Private/Commercial/Non-Profit Transportation Company	Must have Michigan Driver's License and be enrolled in CHAMPS. Must follow all applicable laws, including licensure, inspections, insurance, vehicle maintenance, etc. Must include passenger assistance in the provision of service when needed by passenger.	Secretary of State	Annually

3.4 Home Modifications

Home modifications include physical adaptations to the home that, according to the PCSP, are necessary to ensure the health and welfare of the beneficiary or that enable the beneficiary to function with greater independence in the home. Assessments and specialized training needed in conjunction with the home modifications are included as part of the cost of the service.

This service is available while in the institution to prepare the beneficiary's chosen home and to accommodate a successful discharge to the community. This service may be available in the community

when additional needs that were not accounted for prior to discharge are identified. Claims for this service will not be billed until the beneficiary is discharged from the institution.

Home modifications may include:

- installation of ramps and grab bars;
- widening of doorways to accommodate medical equipment such as a wheelchair or walker;
- modification of bathroom facilities to make them accessible to the beneficiary;
- modification of kitchen facilities to make them accessible to the beneficiary;
- installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and
- environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers or locks.

The case record must document that the home modification is the most cost-effective and reasonable alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home (e.g., converting a dining room on the main floor to a bedroom) or finding alternative housing.

The provider must comply with all local building codes, as applicable. The infrastructure of the home involved in the funded modification must comply with all applicable local codes and have the capability to accept and support the changes.

All home modifications require prior authorization from MDHHS.

3.4.A. LIMITATIONS

The services under the home modification service are limited to additional services not otherwise covered under the State Plan, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Home modifications required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home.

Home modifications will not be approved for rental properties without a close examination of the rental agreement and the proprietor's responsibility to furnish the modification.

Home modifications are not available for condemned structures and must not result in valuation of the structure significantly above comparable neighborhood real estate values.

Home modifications cannot increase the square footage of the home.

Other exclusions are those modifications that:

- are of general utility;
- are considered standard housing obligations of the beneficiary or homeowner; and
- are not of direct medical or remedial benefit to the beneficiary.

Examples of exclusions are:

- carpeting
- roof repair
- sidewalks and driveways
- heating
- central air conditioning
- garages and raised garage doors
- storage and organizers
- hot tubs, whirlpool tubs, and swimming pools
- landscaping
- general home repairs or maintenance

Some exceptions may be considered on a case-by-case basis.

Home modifications exclude costs for improvements exclusively required to meet local building codes.

Home modifications exclude general construction costs in a new home or additions to a home purchased by the beneficiary. If a beneficiary or the beneficiary's family purchases or builds a home while in the process of transitioning, it is the beneficiary's or family's responsibility to ensure the home will meet basic needs (such as having a ground floor bath or bedroom when the beneficiary has mobility limitations). However, home modifications may include assistance with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a recently purchased home.

If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the home modification service may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need.

Billing for home modifications must not be done until the service is completed.

3.4.B. Provider Qualifications

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual	Licensed builder or licensed contractor Michigan license under: MCL 339.601(1), MCL 339.601.2401(1), MCL 339.601.2403(3)	Transition Agency	Prior to provision of services and annually thereafter
		LARA	Annually
Retail Store	Items purchased from retail stores must meet the home modifications service definition.	Transition Agency	Prior to furnishing services and annually thereafter.
Agency/Business	Licensed builder or licensed contractor Michigan license under: MCL 339.601(1), MCL 339.601.2401(1), MCL 339.601.2403(3)	Transition Agency	Prior to provision of services and annually thereafter
		LARA	Annually

3.5 Home and Community-Based Services Personal Care [Change Made 4/1/2025]

Home and Community-Based (HCBS) Personal Care Services enable beneficiaries with functional limitations resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive setting preferred by the beneficiary. HCBS Personal Care Services include the provision of assistance with ADLs (eating, toileting, bathing, grooming, dressing, transferring, and mobility) and IADLs (taking medication, meal preparation, shopping for food or other necessities, laundry, and housekeeping).

HCBS Personal Care Services provided while in the community are limited to beneficiaries who are not eligible for State Plan Personal Care Services (Home Help) or who require personal care services to begin before State Plan Personal Care Services or other HCBS services (e.g., Program of All-Inclusive Care for the Elderly [PACE], MI Health Link, MI Choice) can be authorized. Beneficiaries must not receive both State Plan Personal Care Services and HCBS Personal Care Services at the same time. HCBS Personal Care Services may also be authorized when a beneficiary's needs change and they are unable to quickly secure other personal care services available through the State Plan or a waiver. Services cannot duplicate, replace or supplant other available State Plan services. Beneficiaries enrolled in another HCBS program offering similar services must receive personal care services through that program.

(text deleted per bulletin MMP 24-49) Claims for this service will not be billed until the beneficiary has transitioned to the community.

MDHHS utilizes the reimbursement structures established for State Plan Personal Care Services. The State-developed fee schedule rates depend on the beneficiary's county of residence and whether the provider is an individual or agency. State-developed rates are published on the MDHHS website. (Refer to the Directory Appendix for website information.)

HCBS Personal Care Services require prior authorization based upon a review of the PCSP and the beneficiary's assessed needs.

3.5.A. Provider Qualifications

Provider Type	License or Other Standard	Responsible for Verification	Frequency of Verification
Individual	Must be enrolled in CHAMPS. Must not have any excludable convictions based upon a background check. Must be able to meet the needs of the beneficiary as specified in the PCSP.	Transition Agency	Prior to provision of services and annually thereafter
Agency/Business	Must be enrolled in CHAMPS. Employees and other key staff must not have any excludable convictions based upon a background check. Employees must be able to meet the needs of the beneficiary as specified in the PCSP.	Transition Agency	Prior to provision of services and annually thereafter

3.6 100% State Funded Services [Subsection Added 4/1/2025]

MDHHS allows the following services to be provided to beneficiaries when they are necessary to facilitate a transition to the community. These services are not eligible for Federal Financial Participation.

- First month's rent.
- Payment of delinquent debt that interferes with securing a home in the community.
- A limited quantity of groceries.
- Fees necessary for community living, including fees for a birth certificate, credit checks, or housing application fees required to obtain a lease on an apartment or home.
- Non-emergency, non-medical transportation while in the institution which is limited to visiting potential community-based residences and travel to businesses or agencies to address barriers to community-based living. Examples include going to the bank to open an account or the local Secretary of State office to obtain a State Identification Card.
- Appliances necessary for community-based living.
- Court costs for adding or removing guardianship or conservatorship.

- Personal Care Services provided while the beneficiary is in the institution. These are limited to a one- to three-day trial period in the community-based residence. **(text added per bulletin MMP 24-49)**

3.7 Conflict of Interest Standards [Re-numbered 4/1/2025]

The conflict of interest standards for CTS ensure, at a minimum, that persons performing evaluations, assessments, and PCSP functions are not:

- related by blood or marriage to the beneficiary, or any paid caregiver of the beneficiary;
- financially responsible for the beneficiary;
- empowered to make financial or health-related decisions on behalf of the beneficiary; or
- providers of State Plan HCBS for the beneficiary, or those who have interest in or are employed by a provider of State Plan HCBS, except, at the option of the State, when providers are given responsibility to perform assessments and PCSPs because such individuals are the only willing and qualified entity in a geographic area, and the State devises conflict of interest protections.
- TNs who provide 1915(i) services cannot also be supports coordinators for MI Choice Waiver services.

SECTION 4 – PERSON-CENTERED PLANNING

MDHHS requires that transition agencies and TNs use a person-centered approach in working with beneficiaries.

PCP is a process for planning and supporting a beneficiary that builds on the beneficiary's desire to engage in activities that promote community life and that honor that beneficiary's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the beneficiary desires. TNs must utilize a PCP process that includes assessing the needs and desires of the beneficiary, developing the PCSP, and continuously updating and revising those plans as the beneficiary's needs and desires change. The beneficiary and their chosen representative(s) must be provided with written information from the transition agency explaining their right to participate in the PCP process. Transition agencies must implement the PCP process in accordance with MDHHS guidelines.

PCP meetings are conducted when the beneficiary is not in crisis and at a time of the beneficiary's choice. The beneficiary has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process.

A pre-planning session may occur prior to the first PCP meeting. During the pre-planning session, the beneficiary chooses desires, goals and other topics they would like to discuss, who to invite to the PCP meetings, who will facilitate and record the meeting, and a time and location that meets the needs of everyone involved in the process. The beneficiary and chosen allies design the agenda for the PCP meeting.

The PCP process results in development of the PCSP. The PCSP may otherwise be referred to as a person-centered transition plan (PCTP). Both terms may be used interchangeably for the same plan.

4.1 PERSON-CENTERED SERVICE PLAN

The PCSP is an individualized, comprehensive document developed by the beneficiary, their chosen representatives, and TN. The TN must establish a written PCSP that is based on the beneficiary's expressed needs and desires. The PCSP identifies the beneficiary's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. The document includes all services provided to, or needed by, the beneficiary regardless of funding source. The PCSP includes the amount, frequency, and duration of each service. If risks were discussed during the PCP meeting, beneficiary-approved strategies to mitigate those potential risks are documented in the PCSP.

The beneficiary must approve all services and interventions before implementation, and the TN must document the beneficiary's approval. Regular updates to the PCSP occur when the need for services or circumstances change, or otherwise upon the request of the beneficiary, but at least once every year.

The PCSP must reflect the services and supports that are important for the beneficiary to meet the needs identified through an assessment of functional need, as well as what is important to the beneficiary regarding preferences for the delivery of such services and supports. Commensurate with the level of need of the beneficiary, and the scope of services and supports available, the PCSP must:

- Reflect that the setting in which the beneficiary resides is chosen by the beneficiary. The setting chosen by the beneficiary must be integrated in and support full access of beneficiaries receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work

in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

- Reflect the beneficiary's strengths and preferences.
- Reflect clinical and support needs as identified through an assessment of functional need.
- Include individually identified goals and desired outcomes.
- Reflect the services and supports (paid and unpaid) that will assist the beneficiary to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the beneficiary in lieu of other services.
- Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.
- Be understandable to the beneficiary receiving services and supports, and the individuals important in supporting them. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Identify the individual or entity responsible for monitoring the plan.
- Be finalized and agreed to, with the informed consent of the beneficiary in writing, and signed by all individuals and providers responsible for its implementation.
- Be distributed to the beneficiary and other individuals involved in the plan.
- Prevent the provision of unnecessary or inappropriate services and supports.
- Document that any modifications of the additional conditions specified in the Home and Community Based Services chapter of this manual must be supported by a specific assessed need and justified in the PCSP. The following requirements are documented in the PCSP:
  - identify a specific and individualized assessed need;
  - document the positive interventions and supports used prior to any modifications to the PCSP;
  - document less intrusive methods of meeting the need that have been tried but did not work;
  - include a clear description of the condition that is directly proportionate to the specific assessed need;
  - include a regular collection and review of data to measure the ongoing effectiveness of the modification;
  - include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated;
  - include informed consent of the beneficiary; and
  - include an assurance that the interventions and supports will cause no harm to the beneficiary.

SECTION 5 – ASSESSMENT AND REASSESSMENT

TNs will obtain information from applicants using a community transition assessment approved by MDHHS. The assessment tool contains information about the beneficiary's ability to perform ADLs and IADLs, informal support network, goals for community living, available resources, identification of barriers to transition, how the beneficiary would like to overcome those barriers, and need for CTS. The assessment information will be submitted to MDHHS via the Nursing Facility Transition (NFT) Portal in Compass. MDHHS will review the documentation submitted to verify the beneficiary has Medicaid eligibility and meets the needs-based criteria.

If MDHHS does not have enough information to make an eligibility determination, MDHHS will request additional information from the TN. The TN must provide the additional information if it can be obtained. MDHHS reserves the right to evaluate the applicant in person to confirm that they meet all eligibility requirements for CTS.

During the re-evaluation, the TN will update the community transition assessment tool, including the PCSP. This updated information will be added to the NFT Portal for MDHHS review. MDHHS will review the documentation to ensure the beneficiary still meets criteria for continued receipt of CTS. Beneficiaries must receive at least one of the CTS every three months, and the TN must conduct monthly monitoring.

MDHHS requires TNs to report the initial assessment date and the transition date to MDHHS within the NFT Portal.

Needs-based eligibility re-evaluations are conducted at least every 12 months.

Claims for services will include the actual date of service provision.

SECTION 6 – HOME AND COMMUNITY-BASED SETTINGS

Settings in which a beneficiary resides or receives services must comply with the federal HCBS settings rules, the Home and Community-Based Services policy chapter of this manual, and the Statewide Transition Plan. Transition agencies must ensure that settings to which beneficiaries transition meet federal HCBS settings rules.

Transition agencies must educate beneficiaries that if they choose to live in a setting that does not meet the HCBS settings criteria, Medicaid cannot pay for CTS after the transition date. Medicaid will not pay room and board.

SECTION 7 – BILLING PROCESS

7.1 EXPENDITURE REPORTS

Transition Services Expenditure Reports for CTS provided must be submitted to MDHHS by the 15th day of the month following the month the service was provided. For example, the expenditure report for services provided in January must be submitted to MDHHS by February 15.

The community transition assessment must be updated prior to or upon submission of the Expenditure Report so documentation supports billed services. The NFT Notice must be approved by MDHHS. All expenditures must comply with the established coding structure for CTS (refer to Directory Appendix). Services or items requiring prior authorization will not be payable until approved by MDHHS. Expenditure Reports must be signed by the transition agency prior to submission to MDHHS.

7.2 CHAMPS BILLING

When available, claims must be submitted in CHAMPS. The Professional Invoice claim will be used. Claims may be submitted into CHAMPS via direct data entry or 837P files. Refer to the General Information for Providers and the Billing & Reimbursement for Providers chapters of this manual for claim submission instructions.

The transition agency is the billing provider and will need to have a National Provider Identifier (NPI).

The rendering provider is whomever is providing the service. This provider must have either an NPI or CHAMPS Provider ID. The rendering provider will be included in the header or line on the claim in CHAMPS.

If prior authorization is required for the item or service, the approved prior authorization number must be included on the claim in the "Prior Authorization Number" field.

7.3 PRIOR AUTHORIZATION [CHANGE MADE 4/1/2025]

The prior authorization process is used to approve a specific reimbursement rate for one-time items/services received by a beneficiary. The nature of some CTS makes them inappropriate for fee or frequency screens. There may be instances when a beneficiary has a legitimate need for an item or service that is more expensive than the fee or frequency screen allows. **(text deleted)** Procedure codes must be submitted along with the prior authorization request. Until CHAMPS is programmed to accept prior authorizations for CTS, the Exceptions Process in the NFT Portal must be used.

Claims for all Medicaid-eligible beneficiaries must be submitted in CHAMPS. Providers will use the Professional Invoice claim.

Claims may be submitted into CHAMPS via direct data entry or 837P files. Refer to the General Information for Providers and the Billing & Reimbursement for Providers chapters of this manual for claim submission instructions. **(text revised per bulletin MMP 24-49)**

7.4 Examples of Non-billable Services or Tasks [Changes Made 4/1/2025]

Some tasks performed by transition agencies are not billable. Some examples of these tasks are:

- TN travel time (non-face-to-face visits)
- TN time off (sick leave, vacation)
- Unsuccessful attempts to contact the beneficiary or others on their behalf
- Staff meetings and trainings
- Contact with support staff within the agency
- Filing
- Reviewing case files for quality assurance
- Activities provided by anyone who does not qualify as a TN
- Fees for community living **(text revised/added per bulletin MMP 24-49)**

SECTION 8 – CRITICAL INCIDENT RESPONSE AND REPORTING

TNs are required to track and to report certain events that may indicate exceptional risk to the beneficiary.

8.1 TYPES OF CRITICAL INCIDENTS AND SERIOUS EVENTS

The following are specific critical incidents or serious events that must be reported to MDHHS:

- Provider No Show, particularly when the beneficiary is bed-bound all day or there is a critical need for the service to be provided
- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Medication error
- Neglect
- Physical abuse
- Sexual abuse
- Suicide attempts
- Unexpected/unexplained death related to providing services, supports, or care
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Restraints, seclusion or restrictive interventions

8.2 CRITICAL INCIDENT RESPONSE

TNs have the initial responsibility for identifying, investigating, evaluating, and responding to critical incidents that occur with beneficiaries as listed above. All suspected incidents of abuse, neglect, and exploitation require reporting to MDHHS Adult Protective Services (APS) for investigation and follow-up. TNs must begin investigating and evaluating critical incidents within two business days of the date it was noted that an incident occurred. Suspicious or unexpected death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

Each transition agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with MDHHS-APS to determine the result of the reported incident and the steps to be taken if the results are unsatisfactory. All reports to MDHHS-APS must be maintained in the beneficiary's case record.

8.3 Critical Incident Reporting

TNs are responsible for tracking and responding to critical incidents using the Critical Incident Reporting web-based system. TNs are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of knowledge of the incident. The critical incident system allows MDHHS to review the reports in real time and ask questions or address concerns with the transition agencies. MDHHS must receive notification from transition agencies of suspicious deaths within two business days.

SECTION 9 – ENROLLMENT IN OTHER PROGRAMS

Some beneficiaries may choose to enroll in other Medicaid programs such as the MI Choice Waiver, MI Health Link, PACE, or Home Help after the discharge from the nursing facility. TNs may follow these beneficiaries for up to 30 days to ensure previously planned services are completed. Once the beneficiary is enrolled in these other programs, the transition agency must not bill for any new CTS for which there are similar services offered through the other program.

If a beneficiary is enrolled in Medicaid managed care with a Medicaid Health Plan, the TN must keep the health plan informed that transition work is occurring and when the transition from the institution to a community setting occurs.

If the beneficiary is enrolled in the MI Health Link program when the CTS referral is made to the transition agency, the transition agency must refer that beneficiary back to the MI Health Link Integrated Care Organization with which the beneficiary is enrolled.

SECTION 10 – PROVISION OF NOTICES

Transition agencies must provide each beneficiary the appropriate Adverse Action Notice when the agency terminates, suspends, or reduces previously authorized services, or denies a request for enrollment or additional services. The types of Adverse Action Notices are: 1) Adequate Action Notice, and 2) Advance Action Notice.

10.1 ADEQUATE ACTION NOTICE

The Adequate Action Notice is a written statement advising the beneficiary of a decision to deny or limit authorization of Medicaid services requested. This notice is provided on the same date the action takes effect.

An Adequate Action Notice is also sent to the beneficiary in the following circumstances:

- when the transition agency is unable to schedule an appointment for the community transition assessment within one week of receiving the referral;
- the beneficiary discharges from an institution prior to the transition agency contacting the beneficiary and the assessment could not be conducted;
- the transition agency has information confirming the death of the beneficiary;
- the transition agency receives a clearly written statement signed by a beneficiary who no longer wishes to receive services;
- the beneficiary gives information that requires the termination of services and indicates that they understand termination is the result of supplying this information;
- the beneficiary's whereabouts are unknown and mail is returned without a forwarding address;
- the transition agency determines the beneficiary has eligibility for Medicaid in a different jurisdiction; and
- the date of the action will occur in less than 10 days.

The Adequate Action Notice must contain:

- a statement of the action being taken;
- the reason for the action;
- the regulation(s) that supports the action;
- an explanation of the beneficiary's right to request a State Fair Hearing and instructions for doing so; and
- an explanation that the beneficiary may have self-representation or use legal counsel or another spokesperson.

10.2 ADVANCE ACTION NOTICE

The Advance Action Notice is a written statement advising the beneficiary of a decision to reduce, suspend, or terminate Medicaid services currently provided. This notice is provided at least 10 days prior to the effective date of the action.

The Advance Action Notice must include:

- all Adequate Action Notice requirements;
- the circumstance under which services will be continued pending resolution of the appeal;
- how to request that benefits be continued; and
- the circumstances under which the beneficiary may be required to pay the costs of these services.

10.3 Continuation of Services

The transition agency must continue services after the Advance Action Notice when the following are true:

- the beneficiary specifically requests services to continue and files the appeal within 10 days of the date of the notice;
- the appeal involves termination, suspension, or reduction of a previously authorized service; and
- the period covered by the original authorization has not expired.

10.4 Exceptions to Adverse Action Notices

There are some exceptions to sending Adverse Action Notices. No notice is necessary if the services were for a clearly defined length of time and that length of time has expired according to the PCSP as approved by the beneficiary or their chosen representative, or the service was offered on a one-time only basis.

An Adverse Action Notice is also not required when the determination is a result of a State Fair Hearing decision.

10.5 Exceptions to Advance Action Notice

There are exceptions to sending an Advance Action Notice. According to 42 CFR §431.213, the transition agency may send an Adequate Action Notice in lieu of an Advance Action Notice no later than the date of action if:

- the transition agency has information confirming the death of the beneficiary;
- the transition agency receives a signed, written statement by the beneficiary that:
  - indicates the choice to no longer receive services; or
  - gives information that requires termination or reduction in services and indicates that they understand that this must be the result of sharing that information;
- the beneficiary has been admitted to a penal institution (jail or prison), making the beneficiary ineligible for CTS;
- the beneficiary's whereabouts are unknown and mail is returned with no forwarding address;

- the beneficiary has been accepted for Medicaid services in another locality, state, territory, or commonwealth; or
- there is a change in the level of medical care needed according to the beneficiary's physician.

SECTION 11 – QUALITY ASSURANCE REVIEWS

To ensure the highest quality of services and supports, MDHHS operates a comprehensive quality management system that incorporates evaluations of various aspects of the CTS program. The quality assurance process evaluates beneficiary satisfaction, service provision, service plan development and maintenance, beneficiary records, responses to critical incidents, and other topics. Transition agencies are required to comply with MDHHS requests and requirements for the quality assurance process.

SECTION 12 – CASE CLOSURE

There is no set time limit on how long an individual may use CTS. In general, individuals who transition from the nursing facility are linked to HCBS programs. Once the individual begins receiving services from another program, the need for CTS may end.

- MDHHS allows up to 30 days to facilitate a transfer from CTS to a HCBS program.
- If all is going well with the individual, the transition navigator should close the individual's case at the end of 30 days.
- Reasons for keeping the case open longer than 30 days after starting HCBS must be clearly documented in the case record and approved by MDHHS Home and Community-Based Services Section.
- Not all individuals who transition will qualify for or choose HCBS programs. These individuals may remain open to CTS if they continue to meet eligibility criteria, including the demonstrated and documented need for at least one community transition service on a monthly basis.
- A case may also be closed if the beneficiary is deceased or otherwise not eligible, or has refused services or moved out of the service area and chosen to work with another transition agency.

DENTAL

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SECTION 1 – GENERAL INFORMATION

This chapter applies to dental providers and dental clinics.

Throughout this chapter, the term Medicaid refers to all programs administered by Michigan Department of Health and Human Services (MDHHS), including Healthy Michigan Plan (HMP), ***Healthy Kids Dental*** (*HKD*), MIChild, and other programs, unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

Dental services may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed professionals acting within their scope of practice as defined in State law, including any applicable supervision requirements. Dental services that may be provided to Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures. Determination of medical necessity and appropriateness of services is the responsibility of the dental provider within the scope of current accepted dental practice and the limitations of Medicaid policy.

It is important to verify beneficiary eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.

In compliance with uniform billing, Medicaid follows the Code on Dental Procedures and Nomenclature (CDT) standard procedure codes and descriptions published by the American Dental Association (ADA). Dental providers are required to retain documentation in the beneficiary's dental record that supports the procedure code billed and any information required by the CDT procedure code description. Documentation, including narrative and operative notes, must be sufficiently detailed for audit purposes and made available to MDHHS upon request. For claims that require diagnosis reporting, ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available. (Refer to the General Information for Providers and the Billing & Reimbursement for Dental Providers chapters of this manual for additional information.)

In cases where MDHHS determines that the dental provider did not provide service(s) within the scope of current accepted dental practice or the service(s) was not provided within the limitations of Medicaid policy, MDHHS may:

- Require the service(s) to be immediately provided.
- Require the dental provider to repeat the service(s) at no additional charge.
- Refuse payment to the dental provider for the service(s).
- Recover reimbursement from the dental provider for the service(s).

1.1 Dental Program Coverage

1.1.A. Early and Periodic Screening, Diagnosis and Treatment

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under 21 years of age. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary care providers (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the American Academy of Pediatrics (AAP) periodicity schedule. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter of this manual for additional information.)

1.1.B. Dental Periodicity Schedule

The Dental Periodicity Schedule follows the American Academy of Pediatric Dentistry (AAPD) recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling Schedule. (Refer to the Directory Appendix for AAPD website information.)

The AAPD guidelines are designed for the care of children developing typically and without contributing medical conditions. The guidelines include recommendations to modify as needed for children with special health care needs, disease or trauma. The AAPD guidelines emphasize the importance of early professional intervention and continuity of care based on the individualized needs of the child.

The guidelines recommend that a child have a first dental visit when the first tooth erupts or by no later than 12 months of age. The examination includes assessment of pathology and injuries, growth and development, and caries risk assessment. Based on clinical findings and susceptibility to disease, the timing and frequency of radiographic imaging, oral prophylaxis, and topical fluoride should be provided as determined necessary. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease. Systemic fluoride supplementation should be considered when fluoride exposure is less than optimal.

Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention, and non-nutritive oral habits should be included. A referral for speech/language therapy should be made as needed.

The prevention and treatment of developing malocclusion should be evaluated beginning at two years of age, as determined by assessment of growth and development. Caries-susceptible pits and fissures of teeth should have sealants placed, according to policy, as soon as possible after eruption. Children six years of age and older should receive counseling on substance abuse and intraoral and perioral piercing. Children 12 years of age and older need third molar assessment and potential removal as deemed medically necessary.

1.1.C. Adult Dental Program

Medicaid Fee-for-Service (FFS): Medicaid beneficiaries ages 21 and older who are not enrolled in a Medicaid Health Plan (MHP), Integrated Care Organization (ICO), or Program of All Inclusive Care for the Elderly (PACE) will receive dental benefits through the Medicaid FFS Program.

Medicaid Health Plan (MHP): Medicaid beneficiaries ages 21 years and older who are enrolled in an MHP receive dental benefits through the MHP. The MHP becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the MHP's dental provider network. Questions regarding eligibility, prior authorization (PA), or the provider network should be directed to the beneficiary's MHP.

Healthy Michigan Plan (HMP): HMP beneficiaries enrolled in an MHP will receive dental benefits through the MHP. The MHP becomes responsible for the beneficiary's dental services on the enrollment effective date, and dental services must be obtained through the MHP's dental provider network. Questions regarding eligibility, PA, or the provider network should be directed to the beneficiary's MHP.

Dental services for HMP beneficiaries who are not enrolled in an MHP will be provided through the Medicaid FFS program.

Program of All-Inclusive Care for the Elderly (PACE): PACE is responsible for the coverage of dental benefits for PACE enrollees.

MI Health Link: MI Health Link is responsible for coverage of dental benefits for MI Health Link enrollees.

1.1.D. *Healthy Kids Dental* Benefit

MDHHS contracts with dental health plans (DHPs) for the administration of dental services for *HKD* beneficiaries. Providers must contact the DHP for specific information about covered *HKD* benefits. (Refer to the ***Healthy Kids Dental*** section of this chapter for additional program information.)

1.1.E. Children's Special Health Care Services

The Children's Special Health Care Services (CSHCS) program covers medically necessary services that are related to the beneficiary's CSHCS qualifying diagnosis. CSHCS beneficiaries may be eligible to receive select dental services based on the CSHCS qualifying diagnosis(es) and treatment plan. Not all CSHCS beneficiaries automatically qualify for dental services. (Refer to the Children's Special Health Care Services chapter of this manual for CSHCS program information.)

SECTION 2 – FEE FOR SERVICE DENTAL FREQUENCY VERIFICATION PROCESS

Providers are required to verify with MDHHS that the beneficiary is eligible for a crown, complete denture or partial denture per the five-year rule prior to rendering service. Providers must utilize the Dental Frequency Verification function located in the Community Health Automated Medicaid Processing System (CHAMPS) to ensure the beneficiary is eligible for a crown, complete denture or partial denture per the five-year rule prior to rendering service.

It is the provider's responsibility to verify the five-year rule before providing service and to retain documentation of the screenshot in CHAMPS and date of the response in the beneficiary's dental record. Failure to complete the verification process may result in denied claims.

Frequency verification approval does not guarantee beneficiary eligibility or payment. Prior to rendering services, the provider is responsible for verifying the beneficiary's Medicaid eligibility on each date of service. Refer to the Beneficiary Eligibility chapter of this Manual, Verifying Beneficiary Eligibility section for additional information.

The provider cannot bill the beneficiary for services rendered. Refer to the General Information for Providers chapter of this Manual, Billing Beneficiaries section for additional information.

SECTION 3 – PRIOR AUTHORIZATION

Prior authorization (PA) is required for services identified in this chapter and the Medicaid Code and Rate Reference tool. For questions about medically necessary dental services beyond those described in this chapter, providers should contact the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for website and contact information.)

3.1 PRIOR AUTHORIZATION REQUIREMENTS IN CASES OF MISUTILIZATION

MDHHS may require a dental provider found to be improperly utilizing services to obtain PA for all or selected dental services separate from those generally requiring authorization. MDHHS is required to explain to the dental provider, in writing, the reasons for applying this requirement.

3.2 COMPLETION INSTRUCTIONS

The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. An electronic fill-in enabled version of the MSA-1680-B is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Providers should use the appropriate CDT code(s) on all PA requests. When requesting medically necessary services for which there is no procedure code, the Not Otherwise Classified (NOC) code is used. Services requested under NOC codes require PA. The MSA-1680-B should only include the procedure(s) that requires PA.

The dental provider should provide additional detailed information in the Other Pertinent Dental or Medical History section of the MSA-1680-B to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. Co-existing medical conditions, including pregnancy, should be identified on the PA request along with any effect they might have upon the proposed treatment plan.

When requesting PA, MDHHS may require dental providers to send additional documentation. Additional documentation must contain the beneficiary's name and other identifying information (e.g., Medicaid ID number, date of birth, etc.).

An authorization determination is made based on the MSA-1680-B and the documentation attached. PA requests are assigned a number, posted in the Community Health Automated Medicaid Processing System (CHAMPS), and a notification of decision is sent to the provider. For billing purposes, the PA approval number must be entered in the appropriate field on the claim form.

3.3 CHAMPS WEBSITE

Information on specific coverage parameters and reimbursement rates can be accessed using the Medicaid Code and Rate Reference tool in CHAMPS. Providers should refer to the CHAMPS website for information on previous PA requests, status of current PA requests, and to update or change an approved PA. To assist in the efficient use of this service, providers should have the beneficiary's file, including all necessary data and information, available when making an inquiry.

All other inquiries, such as billing problems, should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

3.4 Approved Prior Authorization Requests

An approved PA confirms that the beneficiary meets Medicaid's established criteria for the services and the services are Medicaid-covered benefits. Approval does not guarantee beneficiary eligibility or payment.

Prior to rendering services, the provider is responsible for verifying the beneficiary's Medicaid eligibility on each date of service. Refer to the Enrollment Information subsection of this chapter and the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.

PA is granted under the National Provider Identifier (NPI) submitted on the MSA-1680-B. PA issued to a group NPI may be used by any individual dental provider within the same group without contacting MDHHS.

PAs are approved for a defined time period, usually six months to one year. If treatment is not completed prior to the end date of the authorization period, the provider must submit the MSA-1680-B to PRD and request an extension of the authorization period for up to six months. When a change in the authorized treatment is necessary, providers must submit the MSA-1680-B with supporting clinical documentation to PRD, identifying the submission as a request for treatment change. The MSA-1680-B should be submitted at least 15 MDHHS business days prior to the end of the authorization period

If a PA request is denied, the beneficiary receives a letter of denial for the requested service along with notice of appeal rights. The provider also receives a copy of the denial letter.

3.5 Loss or Change in Eligibility

Services are not covered after loss or change in eligibility. Root canal therapy, authorized laboratory processed crowns, and authorized complete and partial dentures may be reimbursed if services were started prior to the loss/change in eligibility and completed within the month following the last date of eligibility. Example: If a beneficiary loses eligibility on January 31 and a root canal or denture has already been started, the provider has until February 28 to complete the procedure to be eligible to receive reimbursement.

Reimbursement is not made for the following:

- immediate dentures delivered after the loss/change in eligibility.
- when a beneficiary's eligibility is terminated after extractions were performed, but prior to initial impressions for a denture.

HKD beneficiaries are covered for services completed within 60 days from the date of eligibility loss. Refer to the Healthy Kids Dental section of this chapter for additional information.

3.6 Incomplete Procedures

When root canal treatment, authorized laboratory processed crowns or authorized denture services have commenced but extenuating circumstances have prevented completion (e.g., beneficiary death), providers are paid a reduced rate to offset a portion of the costs incurred. A request to amend the original PA must be submitted as described below.

- Incomplete crown:
  - Providers must request procedure code D2999.
  - Date of service is the date of the impression.
  - Provide the reason treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.
- Incomplete root canal:
  - Providers must request procedure code D3999.
  - Date of service is the date of the first treatment appointment.
  - Provide the reason treatment was not completed.
- Incomplete denture:
  - Providers must request procedure code D5899.
  - Date of service is the date of the initial impression.
  - Provide the reason the treatment was not completed.
  - Submit an itemized statement of the invoice detailing the laboratory costs.

SECTION 4 – COPAYMENT

A copayment for each separately reimbursable Medicaid visit may be required for beneficiaries age 21 and older with the following limitations:

- When more than one reimbursable service is provided during a visit, only one copayment may be charged.
- When several visits are required to complete a service (e.g., dentures), only one copayment may be charged.

A provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.

Some beneficiaries, programs, and places of service are exempt from copayment requirements. Refer to the General Information for Providers chapter of this manual for information on Medicaid copayment requirements. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 5 – PLACE OF SERVICE

All dental services must be performed in a dental office, public health department dental clinic, dental school, dental hygiene program, federally qualified health center, or tribal health center. Special situations may necessitate the provision of services at an alternate site such as a hospital, surgical setting, nursing facility, or mobile dental facility.

5.1 ALTERNATIVE SETTINGS

5.1.A. INPATIENT OR OUTPATIENT HOSPITAL SETTING

Admission to an inpatient or outpatient hospital setting for any non-emergency dental service is covered for beneficiaries for the following reasons:

- The patient has a high-risk medical condition.
- The type of procedure requires it to be performed in a hospital setting.
- Other contributing factors could compromise the safety of the patient, such as age, behavioral problems due to mental impairment, etc.

The dental provider must document in the beneficiary's dental record the condition that required the dental service to be completed in the hospital setting. Hospitalization is not a covered benefit for the convenience of the dental provider or beneficiary or because of apprehension on the part of the beneficiary.

5.1.B. SURGICAL SETTING

For services performed in a surgical setting, the dental provider should use the usual and customary (U & C) charge for the service as performed in an office setting. In addition, the CDT code for hospital or ambulatory surgical center call may also be billed if services are provided in a hospital or surgical center. This code may be billed in addition to the appropriate dental procedure code for the actual service performed. This procedure code is not for administrative purposes, such as arranging appointment times, gathering signatures for release forms, etc.

5.1.C. NURSING FACILITIES

Dental services provided to a beneficiary who resides in a nursing facility are the same benefits as those identified in the Covered Services section of this chapter.

A written order by a licensed referring physician (MD, DO) is required for provision of dental services to a beneficiary in a nursing facility, regardless of place of service. The order must be signed and dated by the physician and a copy of this order must be retained in the beneficiary's medical record and the beneficiary's dental record.

All dental services provided in a nursing facility must be documented in the beneficiary's medical record. Documentation must include the beneficiary's updated medical history, chief complaint, current oral health status, treatment plan, and services rendered.

5.1.D. Mobile Dental Facilities and Public Act 161 (PA 161) Providers

A mobile dental facility is defined as a self-contained, intact facility in which dentistry or dental hygiene is practiced that may be transported from one location to another, or a site used on a temporary basis to provide dental services using portable equipment. The operator of a mobile dental facility and the operator's agents and employees are expected to comply with all federal, state and local laws, administrative rules, regulations and ordinances applicable to the mobile dental facility.

This subsection is designed to be used in conjunction with the MDHHS Oral Health Program Mobile Dental and PA 161 Operations Guide, developed and maintained by the MDHHS Division of Child and Adolescent Health. The Guide is available on the MDHHS Oral Health Program webpage. (Refer to the Directory Appendix for website information.)

A Mobile Dental Facility Permit must be obtained by an operator before providing dental services. A Mobile Dental Facility Permit will be valid for three years from the date of approval. Requirements include:

- Completion and approval of the Mobile Dental Facility Permit Application (DCH-3929);
- Submission of the required documents;
- Submission of the administrative fee; and
- Memorandum of Agreement for follow-up services.

Mobile dental operators can access the DCH-3929, Notification of Change forms, and the Mobile Dental and PA 161 Operations Guide on the MDHHS Oral Health Program webpage. (Refer to the Directory Appendix for website information.)

To provide dental services and bill Medicaid, a provider must be enrolled in CHAMPS. Instructions for provider enrollment, as well as updating enrollment, can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

CHAMPS enrollment as a mobile dental provider is required within 30 days of approval of the DCH-3929. Groups may select more than one specialty. Dental hygienists operating in mobile facilities must enroll as a mobile provider.

5.1.E. Other Sites

Dental services provided at all other sites require PA. In order to receive PA, the dental provider must complete the MSA-1680-B for each individual and submit it to the Program Review Division. Providers should follow the same instructions for submission of the MSA-1680-B for site of service as they do requests for procedures.

SECTION 6 – ANCILLARY SERVICES

6.1 PHARMACY SERVICES

Medicaid has a list of covered drugs that include selected legend and over-the-counter drugs. Medicaid does not reimburse dental providers for drugs dispensed in the office setting.

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDHHS. The MPPL pharmaceutical product coverages may vary by MDHHS program or be limited by age, clinical parameters, and/or gender. (Refer to the Directory Appendix for website information.) For those beneficiaries enrolled in a Medicaid Health Plan (MHP), dental providers should refer to the MHP Common Formulary for the list of approved drugs covered by health plans. (Refer to the Directory Appendix for website information.) The Preferred Drug List is utilized by both Medicaid Fee-For-Service (FFS) and Medicaid Health Plans for pharmacy coverage of select preferred products. (Refer to the Directory Appendix for website information.)

6.2 MEDICAL LABORATORY SERVICES

Medically necessary laboratory services ordered by dental providers are a Medicaid benefit. Only the provider who performs the service may bill for the service.

Ordering practitioners should use their provider NPI number on medical laboratory service orders written for Medicaid beneficiaries. (The laboratory is required to provide this information when billing.)

SECTION 7 – COVERED SERVICES

This section provides information on Medicaid covered services and is divided into subsections that correspond to the categories of services in the CDT published by the ADA:

- Diagnostic Services
- Preventive Services
- Restorative Treatment
- Endodontics
- Periodontics
- Prosthodontics (Removable)
- Oral Surgery
- Adjunctive General Services

Providers must use the current CDT procedure codes when completing both the claim form and MSA-1680-B. Resources are available to assist the provider in determining coverage and coding of specific services, including the Medicaid Code and Rate Reference tool via the external link in CHAMPS and the MDHHS Dental Fee Schedule located on the MDHHS website. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information on code/coverage parameters and the Directory Appendix for website information. Billing information can be found in the Billing & Reimbursement for Dental Providers chapter of this manual.)

7.1 DIAGNOSTIC SERVICES

7.1.A. CLINICAL ORAL EVALUATION (EXAMINATIONS)

A clinical oral evaluation is considered a benefit for all beneficiaries only if detailed written documentation of medical and dental findings (both positive and negative) and tests are included in the beneficiary's dental record. (Refer to the General Information for Providers chapter of this manual for additional information.) Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, occlusal relationships, hard and soft tissue anomalies, oral cancer screening, and denture condition and usage. All clinical oral evaluations must include a diagnosis and treatment plan. Examinations without this documentation are not a covered benefit.

7.1.A.1. COMPREHENSIVE ORAL EVALUATION

A comprehensive oral evaluation is performed on a new patient or an established patient with significant health changes or absence from treatment for three or more years. The evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues (including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions [including periodontal charting], oral cancer screening and appropriate radiographic studies [radiographs are separately

reimbursable]). The comprehensive oral evaluation is a covered benefit for all beneficiaries. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

7.1.A.2. Periodic Oral Evaluation

A periodic oral evaluation is an examination of a patient of record to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs as necessary to update previous radiograph surveys (radiographs are separately reimbursable). A periodic oral evaluation is a covered benefit once every six months for all beneficiaries but may not be billed within six months of a comprehensive oral evaluation. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

7.1.A.3. Limited Oral Evaluation - Problem Focused Exam

A limited oral evaluation-problem focused exam consists of an examination for diagnosis and observation of a specific oral health problem or complaint, such as injuries to teeth and supporting structures. A limited oral evaluation must include appropriate recording of the beneficiary's dental and medical history and charting that is clinically appropriate for the specific problem. In addition, the findings, diagnosis, and treatment plan for the diagnosis must be included in the beneficiary's chart.

A limited oral evaluation can be billed in conjunction with radiographs and/or extractions (simple or surgical) and considered as a covered benefit. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not considered emergency procedures and cannot be billed in conjunction with a limited oral evaluation. Limited oral evaluation-problem focused exam is a covered benefit for all ages.

7.1.A.4. Comprehensive Periodontal Evaluation

A comprehensive periodontal evaluation is a covered benefit for beneficiaries once every 12 months. It is indicated for beneficiaries showing signs or symptoms of periodontal disease and/or with risk factors such as smoking or chronic disease. It includes the evaluation of periodontal conditions, probing and charting, an oral cancer evaluation, and recording of the beneficiary's dental and medical history. A comprehensive periodontal evaluation is not a covered benefit when billed in conjunction with, or within six months of, other clinical oral evaluation codes.

7.1.B. Pre-diagnostic Services

7.1.B.1. Oral Evaluation, Patient <3 Years

An oral evaluation of a patient <3 years of age is performed by a dental provider, preferably within the first six months of the eruption of the first primary tooth. An oral evaluation includes a clinical examination to identify disease, malformation, injury and caries risk. Counseling with the primary caregiver and the development of an

appropriate preventive oral health plan are required. The oral evaluation of a patient <3 years may be billed in conjunction with other dental services but may not be billed on the same date of service as other oral evaluation services.

7.1.B.2. Oral Health Screening of a Patient

An oral health screening of a patient is an inspection of the oral cavity by a PCP as part of the well child exam to determine the need for referral to a dental provider for evaluation and diagnosis. This includes state or federally mandated screenings. Counseling with the primary caregiver and referral to a dental provider, as needed, is required. The oral health screening of a patient may be billed in conjunction with topical fluoride varnish applications but may not be billed on the same date of service as other oral evaluation services. PCPs should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter of this manual for additional information.)

7.1.B.3. Assessment of a Patient

An assessment of a patient is a clinical evaluation performed by a dental hygienist operating in a public health setting or an approved Public Act 161 of 2005 (PA 161) program. Assessment services performed within the scope of dental hygiene practice can be provided to identify signs of disease, malformation or injury and the need for referral for examination, diagnosis and treatment. An assessment of a patient is a benefit for all ages. The assessment must include written documentation of the beneficiary's dental and medical history. Written documentation of significant clinical findings and the appropriate referral is required. The assessment code cannot be used when a dental provider is on site to perform an examination. An oral examination by the dental provider always supersedes the assessment of a patient in place of service settings where the dental provider is present. The assessment can be billed in conjunction with other dental hygiene services but may not be billed on the same date of service as other oral evaluation services.

7.1.C. Consultation

A consultation provided by another dental provider or a physician (MD, DO) is a benefit for all beneficiaries. Medicaid defines a consultation as a service rendered by a dental provider or a physician whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, certified nurse-midwife [CNM], dental provider for the further evaluation and/or management of the beneficiary. The consultant does not render patient care or treatment until the consultant assumes responsibility. If a consultant assumes responsibility for any patient management or treatment, then all services subsequent to the consultation must be billed under the appropriate procedure code (e.g., exams, procedures). If a dental provider provides a consultation, the only separately reimbursable service that may be provided in addition to the consultation are radiographs.

A consultation service includes evaluation of the beneficiary, documentation of history and physical examination findings, recommendations, and submission of a written formal

consultation report to the requesting practitioner. The requesting practitioner cannot bill the consultation procedure code.

A consultation related to routine dental treatment (e.g., caries) is not a covered benefit.

7.1.D. Radiographs

The policy applies to all radiographs and radiographic procedures, both digital and traditional film, unless otherwise stated.

Radiographs are benefits for all beneficiaries and are limited to the number medically necessary to make a diagnosis (other limitations apply to radiographs - see below). The provider must maintain documentation in the beneficiary's file stating the reason the radiographs were necessary, the diagnosis/radiographic findings, treatment plan, and referral if appropriate.

7.1.D.1. Bitewings

Bitewing radiographs are a covered benefit only once every 12 months for all beneficiaries.

7.1.D.2. Occlusal Radiographs

An occlusal radiograph is a covered benefit for beneficiaries under age 21 once every three years per arch.

7.1.D.3. Panoramic Radiographs

A panoramic radiograph is a covered benefit once every five years for all beneficiaries ages five years and older.

7.1.D.4. Full Mouth/Complete Series

A full mouth/complete series is a covered benefit once every five years for all beneficiaries ages five years and older.

A full mouth/complete series consists of:

- A minimum of 10 periapical radiographs in conjunction with a minimum of two bitewing radiographs; or
- An intraoral/extraoral combination of a panoramic radiograph in conjunction with a minimum of two bitewing radiographs.

The maximum reimbursement for any combination of radiographs will not exceed the established fee for a full mouth/complete series. Any combination of 10 or more intraoral radiographs will be considered a full mouth/complete series.

7.1.D.5. Copies of Full Mouth/Complete Series

Dental providers are expected to provide a copy of full mouth/complete series radiographs taken within the previous 12 months to a subsequent provider as requested. Dental providers cannot charge the beneficiary for copying radiographs. (Refer to the General Information for Providers chapter of this manual for additional information.)

7.1.D.6. Radiograph Submission Requirements for Prior Authorization

Providers should not send radiographs with PA unless specifically requested by MDHHS, except in the situations below:

- A periapical radiograph is required when submitting the MSA-1680-B for crowns for beneficiaries who have CSHCS coverage but do not have Medicaid.
- Radiographs (cephalometric, panoramic, full series) are required when submitting the MSA-1680-B for orthodontic treatment coverage by CSHCS. Refer to the CSHCS Enhanced Dental Services section of this chapter for additional information.
- Radiographs may be submitted when a dental provider deems them necessary to evaluate or document the beneficiary's oral condition.

Radiographs that are not specifically requested by MDHHS will not be returned to the provider.

7.1.D.7. Technical Considerations and Additional Requirements

All radiographs submitted (original or duplicates) to MDHHS must be diagnostically acceptable and meet the following technical considerations and additional requirements. Unacceptable radiographs will be returned to the dental provider for replacement with no additional reimbursement provided.

Technical Considerations	▪ All teeth or areas of concern must be visible on the radiographs. ▪ Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty. ▪ On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone. ▪ Where pathologic change is in question, healthy bone must be seen surrounding the questionable area. ▪ Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration. ▪ Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.
Additional Requirements	▪ Traditional film radiographs submitted must be mounted in the correct anatomical order to allow for a thorough and systematic interpretation. ▪ Digital radiographs submitted must be regulation film size and diagnostically acceptable.

	▪ All radiographs must be identified with the beneficiary's name and Medicaid ID number. ▪ All radiographs must have the date the radiograph was taken. ▪ All full mouth/complete series and panoramic radiographs must have "right" and "left" identification. ▪ All radiographs must include the requesting provider's name and address.

7.1.D.8. PHOTOGRAPHS

Photographs are not reimbursed under Medicaid or CSHCS; however, they may be submitted with the MSA-1680-B as supplemental documentation to make the beneficiary's condition clearly visible.

Photographs are part of the pretreatment records for orthodontic services for CSHCS beneficiaries and are not separately reimbursable.

7.2 PREVENTIVE SERVICES

7.2.A. PROPHYLAXIS

Oral prophylaxis is a covered benefit for all beneficiaries once every six months. This service includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface.

If more than one visit is necessary to complete the prophylaxis, it must be billed only once, and the date of service used on the claim must be the date of the final visit.

7.2.B. TOPICAL APPLICATION OF FLUORIDE

Non-Varnish	Topical application of fluoride is a benefit for beneficiaries 6 years of age up to 21 once every six months and cannot be combined with topical application of fluoride varnish within the same six months. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application only if age appropriate.
Varnish	Topical application of fluoride varnish is a benefit for beneficiaries under age 21. Frequency and parameters vary based on the age of the beneficiary as noted below: ▪ Ages 0 through 5: Four times per 12 months as a therapeutic application for all children. ▪ Ages 6 through 20: One time per six months and cannot be combined with topical application of non-varnish fluoride within the same six months.

The following types of fluoride treatment are not covered:

- Treatment that incorporates fluoride with the polishing compound (this is considered to be part of the prophylaxis procedure and is not separately reimbursable);
- Topical application of fluoride to the prepared portion of a tooth prior to restoration;

- Fluoride rinses; and
- The use of self or home fluoride application procedures.

Prescription fluoride supplements may be covered as a pharmacy benefit for beneficiaries under age 16. Prescription fluoride supplements may require PA. (Refer to the Pharmacy chapter of this manual for additional information.)

7.2.C. Interim Caries Arresting Medicament

Interim caries arresting medicament application is a Medicaid covered dental benefit for all ages. Advantage Arrest™ by Elevate Oral Care - Silver Diamine Fluoride (SDF) at 38% is the only Food and Drug Administration (FDA) approved SDF for use in the United States. It is also the only caries arresting medicament allowed by Medicaid policy.

SDF is billable once per date of service regardless of the number of teeth treated, up to a maximum of five teeth per visit. There is a maximum of six applications per lifetime. Direct application to the tooth is required to arrest active carious lesions; however, application to sound teeth is not necessary for the additional anti-caries benefit. Application of SDF has an antimicrobial effect on the entire oral cavity in addition to the teeth being treated for caries arrest. (Refer to the Billing & Reimbursement for Dental Providers chapter of this manual for additional billing information.)

SDF is considered a temporary measure to arrest and slow the progression of caries. It should be used only when traditional methods of restoration are not available or are contraindicated. A minimum of two applications per year has been shown to increase the caries arresting effectiveness. Treated lesions must be monitored over time to assess caries arrest. Additional applications may not be necessary or recommended if caries arrest is still in effect.

SDF is not meant to be used as a full-mouth fluoride varnish therapy. SDF application does not eliminate the need for tooth restoration, nor does it preclude the ability to restore the tooth. It is not used as a base prior to restoration and it has the disadvantage of darkening the carious area of the tooth. SDF will not stain non-carious tooth structure. The darkened tooth structure can be removed with restoration of the tooth.

Indications for SDF use include:	▪ high caries risk ▪ behavioral or medical management issues ▪ dentinal hypersensitivity ▪ caries stabilization ▪ xerostomia from cancer treatment or multiple hyposalivatory medications ▪ treating vulnerable surfaces, such as roots exposed from periodontal attachment loss, overdenture and partial denture abutments, or partially exposed third molars ▪ difficult-to-treat caries lesions (e.g., furcations, margins of fixed bridges) ▪ patients without access to restorative dental services ▪ cognitive disabilities (e.g., patients with autism or dementia)

	▪ physical disabilities ▪ dental phobias
Contraindications for SDF use include:	▪ allergy to silver or other heavy-metal ions ▪ oral ulcerations, stomatitis, or ulcerative gingivitis present at the time of application ▪ more than five teeth treated on the same date of service
Education and Informed Consent	▪ SDF application requires education of providers and staff on the application process, benefits, risks and projected outcomes. Also required is education of the beneficiary and informed consent signed by the beneficiary or guardian. ▪ Treatment with SDF requires more than one application to effectively arrest decay. ▪ Treatment with SDF does not eliminate the need for restorations to repair function or esthetics. ▪ Affected areas will stain black permanently until replaced with a restoration. ▪ Tooth-colored restorations may discolor from SDF but can generally be removed with polishing. ▪ SDF accidentally applied to the skin or gum tissue may stain white or brown if not immediately washed off but will disappear within a couple of weeks. ▪ Although SDF has been proven to be highly successful, application does not guarantee caries arrest.

7.2.D. Sealants

Coverage is limited to fully erupted permanent first and second molars (2, 3, 14, 15, 18, 19, 30, 31), fully erupted first and second primary molars (A, B, I, J, K, L, S, T) and fully erupted first and second permanent premolars (4, 5, 12, 13, 20, 21, 28, 29) for all beneficiaries for the prevention of pit and fissure caries. Sealants are covered once every three years. Medicaid reimbursement includes repair and replacement of the sealant for three years.

Conditions required for coverage include:

- Surfaces must be free from caries.
- Surfaces to be sealed must be free of any restorations.

Medicaid does not cover sealants applied on beneficiaries with:

- Moderate decay.
- Advanced decay.
- Severe decay.
- Previous restoration on identified surface.

7.2.E. Space Maintainers

Space maintainers are covered for beneficiaries under age 13 to maintain a posterior space for a permanent successor of a prematurely lost primary tooth. Only one space maintainer is covered per quadrant. Space maintainers are covered once every two years. When billing for space maintainers, the date of service is the date the space maintainer was delivered to the beneficiary.

7.3 Restorative Treatment

Restorative treatment using amalgam or direct resin-based composite materials to restore carious lesions or fractured teeth is a covered benefit for all beneficiaries. Indirect restorations (crowns) are covered for all beneficiaries. Restorative treatment is limited to those services necessary to restore and maintain adequate dental health. The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary, and a reasonable projection of a successful outcome should be evaluated prior to restoration.

Replacement or repair of all restorations is the provider's responsibility for the first two years following placement. A PA for dentures and partial dentures which includes extraction of the restored tooth within the first two years following placement requires a documented reason for the extraction. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter for additional information regarding coverage parameters.)

Restorations are not covered for deciduous teeth when exfoliation is expected to occur within 180 days. Restorations of deciduous molars and cuspids are not covered for beneficiaries age 12 and older, and restorations of deciduous incisors are not covered for beneficiaries age five and older.

7.3.A. Amalgam Restorations

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are not separately reimbursed and must be included as part of the restoration. If pins are used, they should be reported with the appropriate procedure code.

7.3.B. Resin-Based Composite Restorations – Direct

Resin-based composite refers to a broad category of materials including, but not limited to, composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the restoration. If pins are used, they should be reported with the appropriate procedure code.

7.3.C. Indirect Restorations

Crowns are a covered benefit for all beneficiaries. Crown coverage includes:

Stainless Steel Crowns	▪ Stainless steel crowns are covered for primary teeth and permanent molars. ▪ Stainless steel crowns with resin windows are covered for anterior primary teeth. ▪ Stainless steel crowns are covered only once per two years.
Crowns	▪ Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only. ▪ Porcelain and porcelain fused to metal crowns (indirect) are covered for permanent first and second premolars, canines, and incisors. ▪ Metal crowns only on molars. ▪ Crowns are covered once per five years on the same tooth.

The following are allowed for permanent teeth when a restorative crown will be placed:

- Direct core build-up, including any pins.
- Post and core substructures (indirectly fabricated or prefabricated).

The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary and a reasonable projection of a successful outcome, should be evaluated prior to restoration.

Providers must verify with MDHHS that the beneficiary is eligible for a crown per the five-year rule as described in the Frequency Verification Process section below prior to rendering service. Failure to complete the verification process may result in claim denial.

When billing for laboratory-processed crowns, the date of service is the date the crown was delivered to the beneficiary.

7.4 Endodontics

Endodontics is a benefit for all beneficiaries. The date of service is the date the treatment was completed. (Refer to the Billing & Reimbursement for Dental Providers chapter of this manual for additional information.)

7.4.A. Root Canal Treatment

Root canal treatment is a benefit for all beneficiaries and does not require PA. It is a benefit only where otherwise sound teeth can be reasonably restored under program coverages, and the condition of the rest of the mouth supports this method of treatment.

Program coverage for root canal treatment is solely for the professionally accepted, conventional root canal treatment modalities. These involve complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, non-resorbable filling material. The Sargenti technique is not a covered benefit.

Root canal treatment is a benefit only where otherwise sound teeth can be reasonably restored under program coverages, and the condition of the rest of the mouth supports this method of treatment.

The root canal treatment is not covered if the following conditions exist:

- Furcation pathology is present.
- A posterior tooth has no opposing tooth. (Dentures, partials, fixed bridges, implants, and other prosthetics are considered opposing teeth when present.)
- Tooth is not restorable under Medicaid guidelines.

7.4.B. Pulpotomy

A therapeutic pulpotomy is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth with open apices. It is not considered the first stage of root canal therapy. If exfoliation appears imminent, a pulpotomy is not a covered benefit.

7.4.C. Pulpectomy

Pulpectomy (pulpal therapy) is a benefit for beneficiaries under age 8 on anterior primary teeth and under age 13 on posterior primary teeth when the tooth is nonvital or hemostasis cannot be established by conventional pulpotomy.

7.4.D. Pulpal Debridement

Pulpal debridement is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth prior to conventional root therapy. It is not covered when root canal therapy is completed on the same day.

7.4.E. Apexification

Apexification is a benefit for beneficiaries under age 13 and is limited to permanent teeth when the apex has not completely closed.

7.4.F. Apexogenesis

Apexogenesis is a benefit for beneficiaries under age 21 and is limited to permanent teeth. This service is not considered the first stage of root canal therapy.

7.4.G. Retreatment of Previous Root Canal Treatment

Retreatment of previous root canal treatment is a covered benefit for all beneficiaries once per tooth per lifetime and does not require PA. Retreatment requires the removal of all previous root canal materials and the necessary preparation of the canals for new root canal materials and the necessary preparation of the canals for new root canal filling materials. It includes all procedures necessary for complete root canal treatment and should be considered prior to performing an apicoectomy.

7.4.H. Apicoectomy

Apicoectomy is a surgical procedure to repair a root pathology, defect, fracture and/or removal of extruding filling materials, instruments, or broken root fragments. It also includes the sealing of accessory canals. An apicoectomy should be done only after a tooth has had at least one root canal procedure and retreatment has not been successful or is not possible.

7.5 Periodontics

Periodontal services are a covered benefit for all beneficiaries. Periodontal services are classified as therapeutic and do not fall within the preventive services classification. These services are performed under the general supervision of a dentist.

Documentation for all periodontal services provided must be retained in the beneficiary's dental record for audit purposes and made available to MDHHS upon request.

7.5.A. Full Mouth Debridement

Full mouth debridement is performed as a therapeutic, not a preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It involves the preliminary removal of subgingival and/or supragingival plaque and calculus that interferes with the ability of the dental provider to perform a comprehensive oral evaluation.

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. It may be performed the same day as a comprehensive or periodic oral evaluation when all the required components of the evaluation have been accomplished and documented in the beneficiary's record.

Full mouth debridement is not a covered benefit when performed on the same date of service as a comprehensive periodontal evaluation or when a prophylaxis is completed on the same day.

7.5.B. Scaling in the Presence of Inflammation

Scaling in the presence of inflammation is a benefit for all beneficiaries once every six months. It is indicated for beneficiaries who have swollen, inflamed gingiva, moderate to severe bleeding on probing, and generalized suprabony pockets, but no bone loss. Scaling in the presence of inflammation is not a covered benefit when billed on the same

date of service or within six months of a prophylaxis, scaling and root planing, periodontal maintenance, or debridement procedures.

7.5.C. Periodontal Scaling and Root Planing

Periodontal scaling and root planing is a benefit for all beneficiaries every two years per quadrant when the expected prognosis of the teeth is greater than one year. A maximum of two quadrants or two localized areas can be completed on the same day. PA is required. A single PA request may be submitted for up to four quadrants of periodontal scaling and root planing as PA requests are generally approved for 6 to 12 months. The PA request must include both:

- A copy of the beneficiary's clinical record that specifically documents clinical findings that supports the periodontal diagnosis and need for periodontal treatment, including but not limited to:
  - Dental findings and diagnostic information, health history, clinical notes, treatment procedures performed, treatment plans, and patient-related communications.
- A comprehensive periodontal chart completed within 12 months of the PA request that includes six measurements per tooth and all the following, if applicable:
  - Probing depths > 4mm;
  - Bleeding on probing (BOP) and/or gingival inflammation (e.g., color, contour, consistency of the gingiva);
  - Attachment loss as indicated by documenting the free gingival margin progressing apically;
  - Furcation involvement clinically or radiographically;
  - Mobility.

Periodontal services (scaling and root planing) are not covered if the following conditions exist:

- The expected prognosis of the teeth is less than one year (e.g., pre-treatment prior to extractions, etc.). MDHHS may recover payment in these cases.

7.5.D. Periodontal Maintenance

Periodontal maintenance is a covered benefit for all beneficiaries once every six months. It is performed as therapeutic, not preventive, treatment and indicated following active periodontal treatment. Periodontal maintenance is not a covered benefit when billed in conjunction with prophylaxis, scaling and root planing, scaling in the presence of inflammation, or debridement procedures on the same day.

7.6 Prosthodontics (Removable)

7.6.A. General Instructions

Complete dentures, immediate complete dentures, and partial dentures are benefits for all beneficiaries.

Complete and partial dentures are benefits once per five years per arch when the expected prognosis of the complete or partial denture is at least five years. Complete and partial dentures do not require PA. Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule prior to rendering service, as described in the Frequency Verification Process section of this chapter. Failure to complete the verification process may result in claim denial.

Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the complete or partial denture requested. The provider is expected to evaluate whether the treatment is appropriate for the individual beneficiary, and assess the probability of delivering removable dentures and the beneficiary's compliance with follow-up care.

It is the provider's responsibility to discuss the treatment plan with the beneficiary, including any applicable frequency limits and other pertinent information related to the proposed services, and obtain the beneficiary's agreement with the proposed treatment plan. Documentation of the beneficiary's agreement must be retained in the beneficiary's dental record.

The following documentation must be retained in the beneficiary's dental record and made available to MDHHS upon request:

- Beneficiary understanding and agreement that another denture is not a covered benefit for five years.
- Beneficiary education addressing all available treatment options and documentation of the beneficiary's understanding and agreement.

Before the final impressions are taken for the fabrication of a denture, adequate healing necessary to support the denture must take place following the completion of extractions and/or surgical procedures.

When billing for a complete or partial denture, the date of service is the date the denture was delivered to the beneficiary. Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within six months of insertion.

Complete or partial dentures are not a covered benefit when:

- Medicaid or Medicaid Managed Care has reimbursed a denture in the same arch within five years.
- An adjustment, reline, repair, or rebase will make the current denture serviceable.
- A complete or partial denture obtained through Medicaid within five years has been lost or broken.
- The expected prognosis of the complete or partial denture is less than five years.

7.6.B. Complete Dentures

Complete dentures are a covered benefit for all beneficiaries. Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule prior to rendering service, as described in the Frequency Verification Process section of this chapter. Failure to complete the verification process may result in claim denial.

Only complete dentures with non-characterized teeth (i.e., without cosmetic enhancements, such as gold denture teeth) and acrylic resin bases are a covered benefit. To be covered by Medicaid, all the following procedures must be used to fabricate the dentures:

- individual positioning of the teeth;
- wax-up of the entire denture body; and
- conventional laboratory processing.

A preformed denture with teeth already mounted (i.e., teeth already set in acrylic prior to initial impressions) forming a denture module is not a covered benefit. Overdentures or Cu-Sil® dentures are not a covered benefit.

7.6.C. Immediate Complete Dentures

An immediate complete denture is a definitive denture. It is a covered benefit only when anterior teeth are extracted at the immediate complete denture insertion visit, whether maxillary or mandibular. Medicaid will not cover another denture for five years. Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule prior to rendering service, as described in the Frequency Verification Process section of this chapter. Failure to complete the verification process may result in claim denial.

For reasons of denture stability and retention, an immediate complete denture is not a benefit when:

- Posterior extractions are completed on the same date of service in order to allow adequate healing to support the denture.
- An existing partial denture is converted to an immediate complete denture.

7.6.D. Partial Dentures

Partial dentures are a covered benefit for all beneficiaries over age 16. Providers must verify with MDHHS that the beneficiary is eligible for a complete or partial denture per the five-year rule prior to rendering service, as described in the Frequency Verification Process section of this chapter. Failure to complete the verification process may result in claim denial.

The beneficiary's remaining teeth must be structurally sound to support a partial denture for five years. All clasps are included in the fee for the partial denture.

To ensure that tooth eruption is completed before a permanent appliance is placed, partial dentures are not a covered benefit for beneficiaries under age 16. To replace a lost anterior tooth on a beneficiary under age 16, prior authorization is required. The MSA-1680-B must be submitted for an interim partial denture.

The following benefits are not covered:

- A one-piece cast metal partial denture.
- Immediate partial dentures.
- Elaborate appliance items, such as semi-precision or precision attachments, stress breakers, hinge saddle areas, Kennedy (lingual) blankets.

7.6.E. Interim Complete and Partial Dentures

Interim complete dentures or partial dentures to replace anterior teeth (sometimes called a "stay-plate") are a covered benefit for beneficiaries under age 16. PA is required.

7.6.F. Relines and Repairs

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, duplication, etc. within six months of insertion. If any necessary adjustments or repairs are identified within six months but are not provided until after six months, no additional reimbursement is allowed for these services.

After the initial six months, relines or duplications are covered benefits once within a two-year period. Relines may be laboratory-processed or chairside. Relines and adjustments are not payable on the same date of service.

After the initial six months, repairs and adjustments are covered benefits twice in a 12-month period. If more repairs are needed, they are the responsibility of the treating dental provider. Repairs for interim partial dentures are not covered.

Within five years of delivery, a dental provider is expected to provide the needed services to maintain the existing removable complete or partial denture. This includes extracting teeth, adding teeth to the existing denture, and removing hyperplastic tissue as necessary to restore the functionality of the complete or partial denture.

MDHHS may consider reimbursement for a replacement denture in less than five years when it is more cost-effective to replace the denture than repair it. When submitting the MSA-1680-B for a replacement denture, the provider must provide an explanation of the failure of the current denture and an itemized statement of the repairs needed to make the denture serviceable.

7.7 Oral Surgery

Oral surgical procedures are benefits for all beneficiaries. Detailed operative notes or narrative describing the surgical procedure must be retained in the beneficiary's dental record for all surgical procedures, including surgical extractions. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care. Surgical procedures involving the jaw or facial

bones are considered a medical benefit, not a dental benefit. (Refer to the Practitioner chapter of this manual for additional information.)

The extraction of teeth for prophylactic or orthodontic purposes is not a covered benefit. Dental providers providing enhanced dental services to CSHCS program beneficiaries should refer to the Children's Special Health Care Services Dental Benefits section of this chapter. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information regarding coverage parameters.)

7.7.A. Extractions

Extractions are covered for Medicaid beneficiaries of all ages. The extraction procedure code submitted for reimbursement must follow the CDT guidelines and is not based on the amount of time required, the difficulty of the extraction, or any special circumstances.

A simple extraction of an erupted tooth includes elevation and/or forceps removal. It includes minor contouring of the bone and closure if needed. An extraction is not a covered benefit if exfoliation is imminent.

A surgical extraction requires the removal of bone and/or sectioning of a tooth and may require the elevation of the mucoperiosteal flap. Minor contouring of the bone and closure of the tissue is included. Multiple extractions in the same quadrant for preparation of complete dentures are not considered surgical extractions unless guidelines for surgical extractions are met. The extraction of an impacted tooth is not covered for prophylactic removal of an asymptomatic tooth that does not exhibit pathology.

7.7.B. Tooth Replantation and Fixation

Tooth replantation and fixation is a benefit for beneficiaries under age 21 when permanent anterior teeth are avulsed or displaced due to traumatic injury.

7.7.C. Alveoloplasty

Alveoloplasty is the surgical preparation of the ridge when placement of a prosthesis or other treatments such as radiation therapy and transplant surgery are planned. Alveoloplasty is a covered benefit for all beneficiaries when medical necessity is documented in the beneficiary's dental record.

Reimbursement for an extraction includes minor contouring of the bone. Alveoloplasty performed in conjunction with extractions is a separate and distinct procedure from extractions. Alveoloplasty not in conjunction with extractions is not separately reimbursed when recent extractions have been performed in the same quadrant.

7.8 Adjunctive General Services

7.8.A. Anesthesia

General anesthesia and intravenous (IV) sedation are covered benefits for all beneficiaries when medically necessary. Documentation of medical necessity must be retained in the beneficiary's dental record. General anesthesia and IV sedation may be billed separately from the surgical procedure. A diagnosis code is required on all claims for general anesthesia or IV sedation. General anesthesia and IV sedation may not be billed in combination with each other.

General anesthesia and IV sedation are not covered for the convenience of the dental provider or beneficiary and are limited to situations when these services are medically necessary. Apprehension and/or anxiety about the procedure are not considered valid medical reasons for general anesthesia or IV sedation.

General anesthesia and IV sedation are not covered when used preceding the administration of local anesthesia as the primary anesthetic agent. General anesthesia and IV sedation may not be billed in combination with each other.

Non-intravenous conscious sedation is a benefit for beneficiaries under age 6. It includes the administration of sedative and/or analgesic agents and requires appropriate monitoring in the office setting.

Local anesthesia is not a separately reimbursable procedure. Locally administered anesthetics are included in the reimbursement of the procedure performed.

Refer to the Practitioner chapter of this manual for additional information.

7.8.B. Professional Visits

A hospital or ambulatory surgical center call is a covered benefit for all ages when dental care must be provided in a hospital or ambulatory surgical center for medical reasons. The hospital or ambulatory surgical center call can be submitted in addition to the applicable procedure codes for the services provided on the date of service.

SECTION 8 – NONCOVERED SERVICES

The following dental services are not covered by Medicaid:

- Orthodontics
- Gold foil restorations, inlay/onlay restorations
- Fixed bridges
- Dental implants
- Cosmetic and elective services
- Sports appliances
- Temporomandibular joint (TMJ) services, bite splints
- Services or surgeries that are investigational or experimental in nature
- Dental devices not approved by the FDA

SECTION 9 – CHILDREN'S SPECIAL HEALTH CARE SERVICES DENTAL BENEFIT

The CSHCS program covers medically necessary services that are related to the beneficiary's CSHCS qualifying diagnosis. Providers must be approved by CSHCS and authorized on the beneficiary's file. The CSHCS representative at the local health department should be contacted if there are questions regarding a beneficiary's eligibility for the CSHCS program. (Refer to the Children's Special Health Care Services chapter of this manual regarding CSHCS eligibility, qualifying diagnoses, provider authorization and other CSHCS program information.)

CSHCS beneficiaries may be eligible to receive selected dental services based on the CSHCS qualifying diagnoses and treatment plan. Not all CSHCS beneficiaries automatically qualify for dental benefits. Covered services may include general dental services, CSHCS enhanced dental services, or both.

- CSHCS general dental services are services covered under the Medicaid dental benefit.
- CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual for additional information regarding coverage parameters, including CSHCS covered services and PA requirements.

9.1 CSHCS GENERAL DENTAL SERVICES

CSHCS general dental services are those services covered under the Medicaid dental benefit. Services may include diagnostic, preventive, restorative, endodontics, prosthodontics, and oral surgery. The general dental benefit may include services performed by dental specialists (e.g., endodontists, oral surgeons, etc.). General dental services follow Medicaid coverage parameters, including frequency limits, PA requirements, and age restrictions.

CSHCS beneficiaries under age 21 who are enrolled in both Medicaid and CSHCS receive their general dental benefits through *HKD*. Beneficiaries who are not enrolled in *HKD* due to living arrangements or other factors receive their general dental benefits through Medicaid FFS. CSHCS beneficiaries who are enrolled in HMP receive their general dental benefits through their MHP. CSHCS enhanced dental benefits are administered through Medicaid FFS and are not part of *HKD* or HMP.

9.2 CSHCS ENHANCED DENTAL SERVICES

CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. Examples of enhanced dental services may include orthodontics, dental implants, and crown and bridge services beyond Medicaid's coverage.

Most CSHCS enhanced dental services require PA. Authorization and treatment for enhanced dental services ends when the beneficiary turns 26. (Refer to the Prior Authorization section of this chapter for additional information.) Enhanced dental benefits are described in the individual subsections that follow.

9.2.A. Orthodontic Services

Orthodontic treatment is covered for CSHCS beneficiaries who have a qualifying dental diagnosis that includes orthodontia. Only CSHCS approved orthodontists may provide accepted standards of orthodontic treatment. Services that are non-traditional or experimental are not covered. It is the responsibility of the provider to verify CSHCS eligibility prior to rendering services.

CSHCS coverage ends when the beneficiary turns 26. Services completed on or after the beneficiary's 26th birthday will not be reimbursed. The beneficiary cannot be billed for services completed after CSHCS eligibility ends.

PA is required for each phase of orthodontic treatment, including limited, comprehensive, and continued care. PA requests for orthodontic services must be submitted on the MSA-1680-B. PA requests must be approved prior to the initiation of any treatment. An MSA-1680-B submitted after the initiation of services will be denied, resulting in non-payment of services. The MSA-1680-B requesting orthodontic treatment is approved for a six-month time period.

The following documentation must be included with each completed MSA-1680-B as applicable to each phase of treatment:

- Tooth chart documenting teeth present/absent
- A complete orthodontic treatment plan
- Proposed surgery
- Expected timeframe for completion of treatment
- Radiographs (cephalometric, panoramic, full series)
- Optional: Intraoral and facial photographs (not reimbursed by Medicaid)

9.2.A.1. Pre-Orthodontic Treatment Visit

The pre-orthodontic treatment visit includes the examination and diagnostic casts. Radiographs (full mouth/complete series, cephalometric, panoramic) are reimbursed separately from the evaluation. The pre-orthodontic treatment visit does not require PA.

9.2.A.2. Limited Orthodontic Treatment

The treatment must be deemed necessary to reduce the severity or prevent future effects of a malformation and may involve non-surgical appliances used for palatal expansion. Limited orthodontic treatment is a one-time PA request for the entire time period of treatment.

9.2.A.3. Comprehensive Orthodontic Treatment

Comprehensive orthodontic treatment procedure codes are used when multiple phases of treatment are provided at different stages of orofacial development. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with

each phase of treatment covered for up to two years. There is an initial reimbursement for each stage, with a maximum allowable amount within the two-year period. The submission of the first MSA-1680-B for comprehensive orthodontic treatment must include the appropriate procedure code and the banding/start date of treatment.

9.2.A.4. Periodic Orthodontic Treatment

Periodic orthodontic treatment requires PA. For each six-month time period, a new MSA-1680-B must be approved prior to the continuation of treatment.

Each MSA-1680-B for an additional six-month time period must include the periodic orthodontic treatment code, description of service, and the start date of the six-month treatment period. The periodic orthodontic treatment procedure code may be used up to a maximum of four times per comprehensive orthodontic treatment. This information is necessary for reviewing case histories and verifying the payment status of the beneficiary. No additional PA will be approved if the provider has received the maximum allowable reimbursement for treatment.

9.2.A.5. Debanding/Retention

Debanding and retention are considered part of the limited and comprehensive orthodontic treatment phases and are included in the reimbursement rate. Replacement of lost or broken retainers is allowed twice per lifetime per beneficiary.

9.2.B. Crown and Bridge Services

Qualification for crown and bridge services beyond those covered by Medicaid is based on the specific diagnoses and treatment plan. These services require PA. Not all CSHCS beneficiaries qualify for crown and bridge services.

Replacement will not be made within five years of the insertion date. When billing for crown and bridge services, the date of service is the date the crown or bridge was delivered to the beneficiary.

9.2.C. Implant Services

Dental implants, surgical guides and occlusal guards are covered for CSHCS beneficiaries who have a qualifying diagnosis, including but not limited to, anodontia or traumatic injury to the dental arches, and standard restorative treatment is contraindicated.

Dental implants require PA and must be approved before the initiation of treatment. Submission of the following information is required:

- Complete medical history
- Complete dental history
- Diagnosis
- Treatment plan

- Panoramic radiograph
- Medical justification for the implant services, including the reason alternative forms of prosthetics would not restore function effectively

Providers performing dental implant and adjunctive services must have specialized training in implant procedures (e.g., licensed oral-maxillofacial surgeons or periodontists). Providers must be approved by CSHCS and authorized on the individual CSHCS beneficiary's authorized provider file to receive reimbursement. (Refer to the Children's Special Health Care Services chapter for CSHCS provider approval and authorization information.)

Adjunctive services, including surgical stents, surgical splints and occlusal guards, are covered only when necessary for the success of implant services. Adjunctive services require PA and the dental provider must document the reason services are necessary.

Procedure codes and descriptions for surgical implants, custom or prefabricated abutments, implant supported crowns, occlusal guards and specialized prosthetics are found within the CDT published by the ADA. For additional information regarding coverage parameters, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter of this manual.

When billing for implant procedures, the date of service is the date of completion.

CSHCS coverage ends when the beneficiary turns 26. Services completed on or after the beneficiary's 26th birthday will not be reimbursed. The beneficiary cannot be billed for services completed after CSHCS eligibility ends.

SECTION 10 – HEALTHY KIDS DENTAL

10.1 BENEFIT ADMINISTRATION INFORMATION

MDHHS contracts with dental health plans (DHPs) for the statewide administration of dental benefits for *HKD* beneficiaries. Dental providers must be enrolled in the Michigan Medicaid program via CHAMPS and be a contracted network provider of the DHP to provide dental services to HKD beneficiaries. Providers may choose to participate in one or more DHP networks. HKD beneficiaries access dental services through their DHP network dental provider.

DHPs administer covered dental services according to Medicaid policy, contract requirements, and the DHP's standard policies, procedures, PA, and claim submission process. It is the provider's responsibility to adhere to the DHP's policies and procedures when providing services to *HKD* beneficiaries.

There is no beneficiary copayment for *HKD* services. Reimbursement for covered services rendered to *HKD* beneficiaries is based on the individual DHP's fee schedule. The DHP provides its fee schedule directly to its contracted network providers. Providers must accept the DHP's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. For specific information on a DHP's *HKD* network participation requirements, reimbursement schedule, or other DHP-specific policies and procedures, providers may contact the DHP. (Refer to the Directory Appendix for DHP contact information.)

10.2 COVERED SERVICES

The *HKD* benefit plan covers, at a minimum, all codes listed on the MDHHS Dental Fee Schedule. DHPs must provide the full range of Medicaid covered dental services to beneficiaries but are permitted to develop PA requirements and utilization management review criteria that differ from Medicaid. Questions about covered HKD benefits should be directed to the beneficiary's DHP.

The general categories of dental services listed below are covered by DHPs:

- Emergency dental services
- Diagnostic services
- Preventive services
- Restorative services
- Limited adjunctive services
- Endodontic services
- Crowns
- Periodontal services
- Prosthodontics (removable)
- Oral surgery services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- All medically necessary services

10.3 Beneficiary Identification

Beneficiaries receive a *HKD* DHP identification card upon enrollment in a DHP. Providers must use the DHP identification card when verifying beneficiary enrollment with the DHP.

10.4 Enrollment Information

All newly eligible *HKD* beneficiaries are automatically enrolled in a DHP. The effective date of enrollment in the DHP will be the first day of the month that CHAMPS receives information that the beneficiary has been determined eligible for Medicaid. For example, if CHAMPS is notified that a beneficiary was determined Medicaid eligible on October 24, the beneficiary will have a DHP enrollment effective date of October 1.

Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the beneficiary's DHP. Beneficiaries who are automatically enrolled in a DHP and receive services prior to CHAMPS notification but after the DHP effective enrollment date are eligible to receive services through their assigned DHP for the entire first month of enrollment.

MDHHS mails confirmation letters to all beneficiaries who have been automatically enrolled in a DHP. The letter includes the beneficiary's assigned DHP and information on the right to choose a different DHP.

Before providing services, dental providers must verify Medicaid eligibility and DHP enrollment prior to each appointment to ensure prompt and appropriate reimbursement. Failure to do so may result in unpaid claims for which the provider cannot bill the beneficiary.

10.4.A. Change in DHP Enrollment

A beneficiary may change DHPs within 90 days of the DHP enrollment effective date.

Beneficiaries may contact the MDHHS contracted enrollment broker, MI Enrolls, for help with their DHP selection. MI Enrolls is independent from the DHPs and provides counseling information, including dental provider participation in each DHP's network, to assist beneficiaries in choosing a DHP.

Beneficiaries may contact MI Enrolls to change their DHP. MDHHS also gives beneficiaries the opportunity to change DHPs during each beneficiary's annual open enrollment period. Changes of enrollment are effective on a prospective basis. (Refer to the Directory Appendix for MI Enrolls contact information.)

10.4.B. Voluntary Enrollment

American Indian/Alaska Native *HKD* beneficiaries are a voluntary enrollment population. American Indian/Alaska Native beneficiaries are automatically assigned to a DHP but are given the option to receive dental services through Medicaid FFS. MDHHS mails all new automatically assigned American Indian/Alaska Native beneficiaries confirmation letters informing them of their DHP assignment and the option to choose a different DHP or Medicaid FFS. American Indian/Alaska Native beneficiaries can opt-out of managed care at any time during the beneficiary's enrollment in the *HKD* program. The change of enrollment will be effective prospectively.

10.4.C. Special Disenrollment

Beneficiaries are required to remain in their DHP if they do not make a change during their allotted open enrollment period or within 90 days of their assigned DHP's effective enrollment date. Any request to change DHP outside these time frames requires a good cause justification. Beneficiaries who believe they can show good cause may complete and submit the Special Disenrollment–For Cause Request form (MSA-0176) to MDHHS for review.

Beneficiaries are required to explain their reason for the requested change and may need to include a statement of support from their dental provider. Providers should refer beneficiaries to MI Enrolls for additional information and for instructions on how to obtain the MSA-0176.

10.4.D. Loss of Eligibility

Beneficiaries who lose Medicaid or Children's Health Insurance Program (CHIP) eligibility while enrolled in a DHP during active treatment that requires appointments beyond the last day of eligibility may still be covered if services were started prior to the loss of eligibility (e.g., laboratory processed crowns, root canal therapy, fabrication of dentures, etc.) Services must be completed within 60 days from the date of eligibility loss and billed to the DHP.

10.5 Payment Responsibility for Enrollment Changes

Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the DHP. Beneficiaries may change enrollment status from FFS to a DHP, DHP to DHP, or a DHP to FFS. When a provider has an approved PA for a FFS beneficiary and the beneficiary becomes enrolled in a DHP, the provider must follow the rules of the beneficiary's assigned DHP to deliver dental treatment.

When dental treatment that requires multiple visits (e.g., laboratory processed crowns, root canal therapy, fabrication of dentures, etc.) was started prior to a change of enrollment and the dental provider has incurred costs related to the treatment, the dental provider must use the begin date of service and bill the entity responsible on that date. Treatment must be completed within 30 days after the change of enrollment when billing FFS and 60 days after the change of enrollment when billing a DHP.

- Example 1 (FFS to a DHP): An FFS beneficiary is enrolled in a DHP effective October 1. The provider began root canal treatment on September 26 but does not complete the treatment until October 3. The provider bills Medicaid FFS for the entire root canal treatment using September 26 as the date of service on the dental claim. The treatment must be completed within 30 days after the change of eligibility to be reimbursed. The DHP is not responsible for treatment reimbursement.
- Example 2 (DHP to DHP): A beneficiary is enrolled in a DHP effective October 1, but changes enrollment to another DHP effective November 1. The provider begins fabricating a denture on October 15 but does not deliver the denture until November 10. The provider uses October 15 as the date of service on the dental claim and bills the DHP responsible on that date. The service must be completed within 60 days of the enrollment change to be reimbursed.

- Example 3 (DHP to FFS): A beneficiary is enrolled in a DHP effective October 1, but changes enrollment to FFS effective November 1. The provider begins a laboratory processed crown on October 20 but does not deliver the crown until November 5. The provider uses October 20 as the date of service on the dental claim and bills the DHP responsible on that date. The service must be completed within 60 days of the enrollment change to be reimbursed.

DHPs are required to transition the care of members who were previously receiving active dental services. Providers should contact the beneficiary's DHP for transition of care policies and procedures.

DOULA SERVICES

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SECTION 1 – GENERAL INFORMATION

A doula is a non-clinical person who typically provides physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods. Evidence indicates doula services are associated with improved birth outcomes. Doula services have been shown to positively impact social determinants of health, support birth equity, and decrease existing health and racial disparities.

SECTION 2 – COVERED SERVICES

Medicaid will cover different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. As required by federal regulations at CFR 440.130(c), doula services must be recommended by a licensed healthcare provider. A recommendation for doula services may come from any licensed healthcare provider. Examples of healthcare providers qualified to recommend doula services are those licensed in Michigan as a licensed practical nurse, registered nurse, social worker, midwife, nurse practitioner, physician assistant, certified nurse midwife or physician. MDHHS has obtained a statewide standing recommendation from a licensed healthcare provider for doula services due to their medical necessity for all pregnant or postpartum Medicaid recipients. The statewide standing recommendation applies to every Medicaid beneficiary eligible for doula services and meets program specific documentation requirements for the recommendation. Separate documentation regarding the recommendation by doula providers is not required.

Dependent on person-centered needs, doula support during the perinatal period may include, but is not limited to:

- Prenatal services, which include:
  - Promoting health literacy and knowledge;
  - Assisting with the development of a birth plan;
  - Supporting personal and cultural preferences around childbirth;
  - Providing emotional support and encouraging self-advocacy;
  - Reinforcing practices known to promote positive outcomes such as breastfeeding;
  - Identifying and addressing social determinants of health; and
  - Coordinating referrals to community-based support services (e.g., Women, Infants and Children [WIC] program, behavioral health services, transportation, home visiting services).
- Labor and delivery services, which include:
  - Providing continual physical comfort measures, information, and emotional support;
  - Advocating for beneficiary needs; and
  - Being an active member of the birth team.
- Postpartum services, which include:
  - Educating regarding newborn care, nutrition, and safety;
  - Supporting breastfeeding;
  - Providing emotional support and encouraging self-care measures;
  - Supporting beneficiary in attending recommended medical appointments;
  - Identifying and addressing social determinants of health;

- Coordinating referrals to community-based support services (e.g., WIC, behavioral health services, transportation, home visiting services); and
- Grief support services.

It is the expectation that doula services be provided face-to-face with the beneficiary. Prenatal and postpartum services may be delivered via telehealth. Doula providers will be expected to adhere to current MDHHS telemedicine policy.

Doula services may include a maximum of 12 total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. All prenatal and postpartum visits must be at least a minimum of 20 minutes in duration with a beneficiary to be considered eligible for reimbursement. Additional visits beyond the limits in policy may be requested through the prior authorization (PA) process. PA requirements for MHP enrollees may differ from those required for Fee-for-Service (FFS) beneficiaries. Providers should contact the individual MHPs regarding their authorization requirements.

A qualifying visit for attendance at labor and delivery requires the doula to be physically present during labor, delivery, and the immediate postpartum period. Physical presence at birth includes doulas who remain on-site at the facility.

Documentation must include a start time and end time of services provided, a description of the professional services rendered, and information regarding the source of the licensed healthcare provider recommendation for services if a doula chooses not to rely on the statewide recommendation. Documentation must be kept in accordance with the record keeping requirements of the Medicaid program and may be subject to review and post-payment audit.

SECTION 3 – PROVIDERS

3.1 PROVIDER CRITERIA

Qualified individuals must be at least 18 years of age and possess a high school diploma or equivalent. MDHHS will include doulas who have completed training provided by an MDHHS-approved doula training program or organization on the MDHHS Doula Registry. Doulas must provide proof of training to MDHHS upon request.

At a minimum, a doula training program must include skill development in the following areas:

- Communication, including active listening, cross-cultural communication, and interprofessional communication,
- Perinatal self-care measures,
- Coordination of and linkage to community services and resources,
- Labor and coping strategies, and
- Newborn care and supportive measures.

MDHHS-approved qualified doula training programs or organizations can be found on the MDHHS Doula Initiative website. (Refer to the Directory Appendix for website information.)

It is the expectation that doula providers will work within their scope of training. MDHHS, with community input, will continue to review doula training programs, including those created for specific populations such as community-based doula programs, to support cultural and community needs.

3.2 PROVIDER ENROLLMENT

Doula providers seeking reimbursement for their professional services to Medicaid beneficiaries are required to be Medicaid-enrolled providers. To enroll as a Medicaid provider, a doula must have a Type 1 (Individual) National Provider Identifier (NPI) and complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS). As part of the enrollment process, individually enrolled doulas may also associate their enrollment with Medicaid-enrolled organizations with a Type 2 (Group) NPI.

Doulas providing services to Medicaid beneficiaries are required to be registered with the MDHHS Doula Registry to enroll as a Medicaid provider. Additional details regarding the MDHHS Doula Registry are available on the MDHHS Doula Initiative website. (Refer to the Directory Appendix for website information.)

Doula providers are also subject to all relevant policy provisions outlined in the MDHHS Medicaid Provider Manual, including the General Information for Providers Chapter.

SECTION 4 – REIMBURSEMENT

4.1 REIMBURSEMENT CONSIDERATIONS

For doula services rendered to beneficiaries enrolled in an MHP, providers will submit claims to the beneficiary's assigned MHP. If a beneficiary is not enrolled in an MHP, doula providers will submit claims for FFS reimbursement through CHAMPS.

- Claims are to be submitted utilizing the pregnant or postpartum beneficiary's Medicaid identification (ID) number.
- Medicaid will provide reimbursement for the first eligible claims submitted for these services up to the limit of 12 total prenatal and postpartum visits and one visit for attendance at labor and delivery.
- Claims must include a primary diagnosis code and modifier HD to support the services billed. In addition, doulas are encouraged to report the appropriate International Classification of Diseases 10 (ICD-10) diagnosis codes within the range of Z55-Z65 to describe any relevant social determinants of health (e.g., Z56.1 change of job, Z59.1 inadequate housing, Z59.4 lack of adequate food and safe drinking water).
- For additional doula services billing information, refer to the Billing & Reimbursement for Professionals chapter.

4.2 PRIOR AUTHORIZATION (PA) CRITERIA

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid, such as additional visits. PA requests should be related to physical, emotional, and educational support services to pregnant individuals during the prenatal and postpartum periods.

Approval for a maximum of six additional visits is dependent on person-centered needs. Requests should include at least one of the following criteria:

- Promoting health literacy and knowledge
- Assisting with the development of a birth plan
- Supporting personal and cultural preferences around childbirth
- Providing emotional support
- Encouraging self-advocacy
- Reinforcing practices known to promote positive outcomes, such as breastfeeding
- Identifying and addressing social determinants of health
- Educating regarding newborn care, nutrition, and safety
- Supporting breastfeeding
- Encouraging self-care measures
- Supporting beneficiary in attending recommended medical appointments
- Identifying and addressing social determinants of health

- Grief support services
- Coordinating referrals to community-based support services (e.g., Women, Infants and Children [WIC] program, behavioral health services, transportation, home visiting services)

PA requests for Fee-For-Service may be submitted by the following methods:

- In writing, via Direct Data Entry (DDE) in the Community Health Automated Medicaid Processing System (CHAMPS). No PA form is required if the request is submitted this way, but the provider will need to include a statement in the procedure comments explaining the need for extra visits.
- By faxing form MSA-1653-B and including a statement on the form or on the fax cover sheet explaining the need for extra visits.

Providers will receive a hard copy of the PA determination letter to the address selected in CHAMPS (located in the pull-down list when a DDE request is entered). If the form is faxed, the address indicated on the form should ideally match the communication address used to enroll in CHAMPS.

Refer to the General Information for Providers chapter for additional information regarding prior authorization of services.

4.3 Federally Qualified Health Center and Rural Health Clinic Reimbursement

Doula services provided by a FQHC or RHC do not qualify as an encounter. The services may, however, be reimbursed outside of the Prospective Payment System (PPS).

4.4 Indian Health Center Reimbursement

Doula services provided by a Tribal Health Center (THC) or Tribal Federally Qualified Health Center (FQHC) do not qualify as an encounter. The services may, however, be reimbursed outside of the All Inclusive Rate (AIR).

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

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SECTION 1 – GENERAL INFORMATION

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions discovered whether or not such services are covered under the state plan. State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age. Accordingly, EPSDT well child visits and any needed follow-up services are covered by Medicaid.

EPSDT visits cover any medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are available to all children for the purpose of screening and identifying children who may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, trauma, failure to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations.

EPSDT visits are to be performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. Michigan recognizes the AAP definition of "medical necessity" as:

> *Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.*

EPSDT requires the coverage of medically necessary inter-periodic screenings outside of the AAP periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

Medically necessary services include habilitative or rehabilitative services that are expected to attain, maintain, or regain functional capacity and to achieve maximum health and function. A service need not cure a condition in order to be covered under EPSDT, and maintenance services or services that improve the child's current health condition are also covered in EPSDT because they ameliorate a condition. The common definition of ameliorate is "to make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. It is important to identify illnesses and conditions early and to treat any health problems discovered in children before they become worse and more costly. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. Refer to the Special Coverage Provisions section of the Healthy Michigan Plan chapter for the definition of “habilitative services”.

EPSDT includes a broad range of services that can be covered and includes:

- licensed practitioners services;
- speech, occupational, and physical therapies;
- physician services;
- private duty nursing;
- personal care services;
- home health;
- medical equipment and supplies;
- habilitative and rehabilitative services;
- vision services;
- hearing services; and
- dental services.

In addition, the coverage of other diagnostic, screening, preventive and rehabilitative services is required, and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The coverage of EPSDT services is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit.

The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular physical, behavioral, mental, or dental health needs of the child. While the treating provider is responsible for determining or recommending that a particular service is needed to correct the child's condition, both the Michigan Department of Health and Human Services (MDHHS) and a child's treating provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating provider, health plan, and/or Medicaid as to whether a service is medically necessary for a particular child, Medicaid is responsible for making a decision for the individual child based on information presented to departmental staff. The MDHHS Office of Medical Affairs consists of a panel of physicians, including pediatricians, who will review the medical necessity of a particular service when there is a disagreement between the treating provider, health plan or Medicaid. These physicians review, on a case-by-case basis, the particular needs of the child based on the medical standards and literature, and in consultation with subspecialists when appropriate in accordance with Michigan Medicaid policy.

A medically necessary treatment service should not be denied to a child based on cost alone, but the relative cost effectiveness of alternative services may be considered as part of the prior authorization process. Services may be covered in the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually. Prior authorization is not required for medically necessary screenings.

The main parts of the EPSDT program that providers are responsible for are:

- Well child visits, including immunizations and developmental screening, using a validated and standardized screening tool at specified intervals as defined in the periodicity schedule by the AAP (hereafter referred to as the "AAP periodicity schedule"). A copy of the AAP periodicity schedule is available on the AAP website. (Refer to the Directory Appendix for website information.)

  NOTE: The AAP periodicity schedule requires a risk assessment to be performed for vision, hearing, and blood lead screening at the specified intervals. MDHHS requires vision, hearing, and blood lead testing to be performed at the specific ages indicated on the AAP periodicity schedule. A parent/guardian (or person in loco parentis) applying to register a child for the first time in kindergarten or first grade in a school in this state shall present to school officials, at the time of registration or no later than the first day of school, a certificate of hearing and vision testing or screening or a statement of exemption. Refer to the appropriate section within this chapter for MDHHS requirements regarding vision, hearing, and blood lead screening.
- Referrals for:
  - Other preventive health care;
  - Medically necessary follow-up services to treat detected conditions; and
  - Transportation for health care services.

SECTION 2 – AAP PERIODICITY SCHEDULE AND COMPONENTS

The AAP periodicity schedule and its components are available on the AAP website, and they are to be followed for well child visits. (Refer to the Directory Appendix for AAP website information.)

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. MDHHS urges providers to cooperate with these agencies. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

Providers must complete all testing components at the ages indicated on the AAP periodicity schedule. Well child visits may be performed more frequently than the AAP periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record must reflect documentation of the circumstances.

The following sections follow the AAP periodicity schedule and are meant to provide further guidance to providers. The sections include additional policies and procedures to be performed that are beyond the AAP periodicity schedule guidelines.

SECTION 3 – HISTORY AND WELL CHILD VISITS

An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit. MDHHS supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider (PCP) who assumes responsibility for assuring the overall care of a beneficiary, and for the maintenance and updating of a beneficiary's medical record. When a PCP accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing EPSDT well child visits.

Well child visits are the health check-ups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes.

The AAP periodicity schedule indicates all components and age-specific indicators for performing the various components. Developmental screening, using an objective validated and standardized screening tool as recommended by the AAP, should be performed at the specified intervals.

SECTION 4 – MEASUREMENTS

4.1 LENGTH/HEIGHT AND WEIGHT

Length, height, and weight must be measured using standardized techniques each time the PCP conducts a well child visit, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the Centers for Disease Control and Prevention (CDC) website. (Refer to the Directory Appendix for website information.)

4.2 HEAD CIRCUMFERENCE

A head circumference measurement is required at each well child visit through 24 months of age.

4.3 WEIGHT FOR LENGTH

Weight for length must be measured each time the PCP conducts a well child visit through 18 months of age, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

4.4 BODY MASS INDEX (BMI)

Body mass index (BMI) must be measured each time the PCP conducts a well child visit for children 24 months of age and older, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

4.5 BLOOD PRESSURE

PCPs must obtain a blood pressure reading at each well child visit beginning at 3 years of age. Blood pressure measurement in infants and children with specific risk conditions should be performed at well child visits before 3 years of age.

SECTION 5 – SENSORY SCREENING

5.1 VISION SCREENING

PCPs are to perform a subjective vision screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children 3 years of age and older, an objective screening must occur as indicated on the AAP periodicity schedule. An objective vision screening is accomplished using a standardized screening tool. A visual acuity screen is recommended at 4 and 5 years of age, as well as in cooperative children 3 years of age. Instrument-based screening may be used to assess risk at 12 and 24 months of age, in addition to the well child visits at 3 through 5 years of age. MDHHS requires vision testing at specific well child visits for children 3 years of age and older.

5.1.A. PRESCHOOL

An objective vision screening may be performed on Medicaid eligible preschool-age children each year beginning at 3 years of age through 6 years of age by qualified Local Health Department (LHD) staff. If the child is uncooperative, the screening should be re-administered within six months. LHDs may provide objective vision screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective vision screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective vision screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

5.1.B. REFERRAL

For children of any age, referral to an optometrist or ophthalmologist should be made if there are symptoms or other medical justification (e.g., parent/guardian has suspicions about poor vision in the child). A routine eye examination by an optometrist or ophthalmologist once every two years is a Medicaid benefit and does not require prior authorization.

5.2 HEARING SCREENING

Providers are to perform a subjective hearing screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children, an objective screening must occur as indicated on the AAP periodicity schedule. Screen the child with audiometry, including 6,000 and 8,000 Hz high frequencies, once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. Confirm the initial screen was completed, verify the results as soon as possible, and follow-up as appropriate.

5.2.A. Newborns/Infants

All newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. The hospital must provide newborn hearing screenings for Medicaid-covered newborns as indicated by the AAP. If the newborn fails the first screening, another screening must be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. If the hospital is not equipped for EOAE and/or ABR, the newborn's PCP must be made aware of this fact by the hospital so the newborn can be referred for a hearing screening prior to 1 month of age.

For infants who do not pass ABR testing in the neonatal intensive care unit (NICU), a referral should be made directly to an audiologist for rescreening and, when indicated, a comprehensive evaluation including ABR. For rescreening, a complete screening on both ears is recommended, even if only one ear failed the initial screening. For readmissions in the first month of life for all infants, when there are conditions associated with potential hearing loss, a repeat hearing screening is recommended before discharge. All infants who do not pass the initial hearing screening and the subsequent rescreening should have appropriate audiological and medical evaluations to confirm the presence of hearing loss at no later than 3 months of age. All infants with confirmed permanent hearing loss should receive early intervention as soon as possible after diagnosis but at no later than 6 months of age.

The results of all hearing tests and screenings conducted on infants who are younger than 12 months of age must be reported to the MDHHS Early Hearing Detection and Intervention (EHDI) program. The Audiological/Medical Follow-up Services Report form (DCH-0120) is to be completed and shall include the type, degree, and symmetry of the diagnosis, along with where and when the diagnosis was made. The form is to be submitted to the EHDI program. (Refer to the Directory Appendix for contact and form information.)

Refer to the Newborn Hearing Services subsection of the Hearing Services and Devices Chapter for additional information.

5.2.B. Preschool

An objective hearing screening may be performed on Medicaid eligible preschool-age children by qualified LHD staff. LHDs may provide objective hearing screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective hearing screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective hearing screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results of all hearing tests and screens conducted on children who have been diagnosed with hearing loss who are younger than 3 years of age must be reported to the EHDI program. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

5.2.C. Referral

A referral to a hearing center, audiologist, otologist, or Children's Special Health Care Services (CSHCS)-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification for further objective testing or diagnosis.

SECTION 6 – DEVELOPMENTAL/SOCIAL/BEHAVIORAL/MENTAL HEALTH

Developmental/social/behavioral/mental health screenings, surveillance, and/or assessment are required at each scheduled EPSDT well child visit from birth through adolescence as recommended by the AAP periodicity schedule and as indicated in the following subsections. The PCP should screen all children for developmental and behavioral concerns, including engaging in risky behavior, using a validated and standardized screening tool as indicated by the AAP periodicity schedule.

If the screening is positive or suspected problems are observed, further evaluation must be completed by the PCP, or the child should be referred for a prompt follow-up assessment to identify any further health needs. The provider may administer additional screenings, surveillance, or assessments as described in the following subsections.

6.1 MATERNAL DEPRESSION SCREENING

Screening for maternal depression with a screening tool, such as the Edinburgh scale, is to be performed by the infant's PCP as recommended by the AAP periodicity schedule. It is intended that the service should be reported and billed under the infant's Medicaid ID number using the appropriate Current Procedural Terminology (CPT) code as it is a service rendered for the benefit of the infant. If the screening is positive, the PCP should address the mother-child dyad relationship (attachment and bonding), follow-up, and refer as appropriate.

6.2 DEVELOPMENTAL SCREENING

A developmental screening using an objective validated and standardized screening tool must be performed following the AAP periodicity schedule at 9, 18 and 30 (or 24) months of age, and during any other preventive health care well child visits when there are parent/guardian and/or provider concerns. Developmental screening may be accomplished by using a validated and standardized developmental screening tool such as the Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS). If the screening is positive, PCPs should further evaluate the child, provide counseling, and refer the child as appropriate. A maximum of three objective standardized developmental screenings may be performed in one day for the same beneficiary by a single provider. (Refer to the Billing & Reimbursement for Professionals chapter for billing instructions.)

6.3 AUTISM SPECTRUM DISORDER SCREENING

A validated and standardized screening tool must be administered as part of the well child visit by a physician. Proper assessment of autism spectrum disorder is accomplished by administering a validated and standardized screening tool, such as the Modified Checklist for Autism in Toddlers (M-CHAT), at 18 and 24 months of age as indicated by the AAP periodicity schedule. Surveillance for Autism Spectrum Disorder (ASD) must be completed during other well child visits beginning at 12 months of age by listening for parent/guardian concerns and by watching for red flag abnormalities, such as no babbling by 12 months of age. Children 24 months of age and older who have not been screened may be screened during preventive health care well child visits using a validated and standardized screening tool such as the M-CHAT or the Social Communication Questionnaire (SCQ).

The screening tool may be completed by the parent/guardian and reviewed/verified by the PCP. The M-CHAT is validated for children 16 through 30 months of age. For children 4 years of age and older (mental age greater than 2 years of age), the SCQ may be utilized. For children 30 months through

4 years of age, the more applicable of the two screening tools should be administered (M-CHAT if mental age is younger than 2 years of age; SCQ if mental age is greater than 2 years of age). If the screening is positive, the PCP should contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. (Refer to the Directory Appendix for the National Autism Center contact information and for additional resources regarding ASD.)

6.4 Developmental Surveillance

Developmental surveillance should occur at every well child visit throughout childhood and must be performed as indicated by the AAP periodicity schedule. Developmental surveillance includes eliciting and attending to parent/guardian concerns, maintaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings. Further investigation, an appropriate referral, and/or an early return visit should be scheduled for children whose surveillance raises concerns that are not confirmed by a developmental screening tool.

6.5 Behavioral/Social/Emotional Screening

The behavioral/social/emotional screening should be family-centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. A behavioral/social/emotional screening is to be performed during each well child visit from newborn through 21 years of age in accordance with the AAP periodicity schedule, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines.

The behavioral/social/emotional screening may be accomplished by using an evidence-based, validated and standardized screening tool such as the Ages and Stages Questionnaire – Social-Emotional (ASQ-SE) or Pediatric Symptom Checklist (PSC), with appropriate action to follow if the screening is positive. Providers should establish office routines for screening and surveillance. Children with significant risk factors should be monitored with heightened surveillance and more frequent screening. The use of validated and standardized screening tools improves the detection rate of social-emotional problems in children compared to the reliance on subjective clinical judgment.

A behavioral/social/emotional screening should also be performed whenever there are general development delays; at any time the clinician observes poor growth, poor attachment, or symptoms such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and/or at any time the parent/caregiver identifies behavioral or social-emotional concerns.

If the screening is positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate. (Refer to the Children in Foster Care section of this chapter for more information regarding the administration of a behavioral/social/emotional screening for children in foster care.)

6.6 Tobacco, Alcohol or Drug Use Assessment [Change Made 4/1/2025]

A tobacco, alcohol or drug use assessment must be performed annually at each preventive health care well child visit beginning at 11 years of age and as indicated by the AAP periodicity schedule **(added 4/1/2025)** or when there are circumstances suggesting the possibility of substance abuse beginning at an earlier age. A risk assessment should be administered and, if necessary, the child should be screened for tobacco, alcohol, and other drug use with a validated and standardized screening tool, such as the

CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screen. If the assessment and screening are positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate.

6.7 Depression and Suicide Risk Screening

A depression and suicide risk screening is to be performed annually for all adolescents who are 12 years of age until 21 years of age as indicated by the AAP periodicity schedule and per the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). A depression screening may be accomplished using a standardized screening tool such as the Patient Health Questionnaire-9 (PHQ-9), PHQ-9 modified for Adolescents (PHQ-A), or other screening tools available in the GLAD-PC toolkit. Every effort should be made to preserve the confidentiality of the adolescent. Any information obtained during the visit should only be shared outside of the office with the permission of the parent or caregiver to protect the adolescent's safety. (Refer to the Directory Appendix for website information.)

SECTION 7 – TRAUMA SERVICES

Children under 21 years of age are covered for trauma-related services under the EPSDT benefit. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the child's functioning and physical, social, or emotional well-being. According to adverse childhood experiences (ACEs), adverse early trauma experiences are related to increased rates of health problems in adulthood including obesity, cardiovascular disease, substance use, mental health problems, social risk factors, and poor health-related quality of life. "Toxic stress" is described as a type of unremitting stress that ultimately compromises a child's ability to regulate their stress response system effectively and can lead to adverse long-term structural and functional changes in the brain and elsewhere in the body. Trauma-specific interventions should be identified to reduce the prevalence and consequences of ACEs and trauma. Trauma-specific interventions generally recognizes the following:

- The child's need to be respected, informed, connected, and hopeful regarding their own recovery;
- The interrelation between trauma and symptoms of trauma such as substance use, eating disorders, depression, and anxiety; and
- The need to work in a collaborative way with the child, family and friends of the child, and other human services agencies.

The primary care provider (PCP) should:

- Strengthen their provision of anticipatory guidance to support children's social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques;
- Actively screen for precipitants of toxic stress that are common in their particular practices;
- Assess the child's exposure to trauma and risk of exposure to trauma using a questionnaire or screening tool. Screening tools are available through the American Academy of Pediatrics (AAP); and
- Identify (or advocate for the development of) local resources that address risks for toxic stress that are prevalent in their communities.

Providers may use current best practices to screen for precipitants of toxic stress. Examples of current trauma screening tools, as indicated by the AAP, include:

- Adverse Childhood Experiences Questionnaire (ACE-Q)
- Resilience Questionnaire
- Pediatric Intake Form

History of trauma may or may not be disclosed by the family or child. The PCP may need to ask about possible current or past exposure to traumatic events and assess for the child's safety. Questions may be targeted when there are unexplained somatic complaints or other indicators that may be associated with exposures to trauma or adversity. The PCP may consider asking the caregiver and/or child explicitly about the exposure to trauma. Providers may refer to the AAP policy statement for questions to ask parent/caregivers. Examples of those questions include:

- "Has your home life changed in any significant way (e.g., moving, new people in the home, people leaving the home)?"
- "Do you have any concerns about your child's behavior at home, child care or school, or in the neighborhood? Has your child's teacher mentioned any concerns?"
- "Many children are exposed to violence at home, in the neighborhood, at school or with friends. Do you think your child may have been exposed to violence?"
- "All children are exposed to stress. Sometimes stress can make a child sad or scared. Do you have any concerns about your child's stress?"

Examples of questions to ask the school-aged child include:

- "Are you having any problems at home, at school, or in the neighborhood?"
- "Do you feel safe at home and/or at school?"
- "How do you deal with stress?"

7.1 Referrals for Behavioral Health Services/Therapy

If the screening is positive, the PCP should refer the child to a mental health professional trained to provide trauma assessment, treatment using a trauma-specific model, and/or support. Behavioral health services are a Medicaid covered service.

Behavioral health services are covered by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for the services included under the capitation payments to the PIHPs/CMHSPs. A limited outpatient benefit is covered for children enrolled in a Medicaid Health Plan (MHP) or through Fee-for-Service (FFS) Medicaid.

In general, MHPs are responsible for outpatient mental health treatment when the child is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior. For children not enrolled in a MHP, behavioral health services are covered through FFS Medicaid. Under FFS, behavioral health services may be provided by a physician (MD or DO), physician assistant, nurse practitioner, psychologist, social worker, professional counselor, or marriage and family therapist working within their scope of practice under State law.

In general, PIHPs/CMHSPs are responsible for outpatient mental health treatment for a child with a serious emotional disturbance as indicated by the diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities. The child may experience substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. For children not enrolled in an MHP and for services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through FFS Medicaid. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information. Additional information is also available on the MDHHS website; refer to the Directory Appendix for website information.)

SECTION 8 – PHYSICAL EXAMINATION

A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed and older children must be undressed and suitably draped. If the patient is an adolescent or young adult and the examination requires inspection or palpation of anorectal or genital areas and/or the female breast, a chaperone is recommended. The use of a chaperone should be a shared decision between the patient and the PCP. If the patient declines the use of a chaperone, the provider should document this fact in the medical record. The purpose of the well child examination is to promote health, detect medical problems, and to counsel in order to prevent injury and future health problems. The physical examination also provides opportunities to educate children, adolescents, and their parents/guardians about the body and the growth and development process. The physical examination must be comprehensive and appropriate for the infant's, child's, or adolescent's age, gender, and developmental status, and should build on the history gathered during previous medical and well child visits. The provider should review the scope and findings of the examination with the patient and parents/guardians at the completion of the examination. This review should be documented in the medical record.

SECTION 9 – PROCEDURES

9.1 NEWBORN BLOOD SCREENING

A provider in charge of the care of a newborn child shall administer or cause to be administered to the newborn child a newborn blood screening test. Hospitals must test newborns for over 50 disorders as indicated by the AAP periodicity schedule and as required by Michigan law. The complete list of disorders is determined by MDHHS. If the results of a test administered are positive, the results shall be reported to the newborn child's parents/guardians. Blood samples are to be sent to the MDHHS Bureau of Laboratories Newborn Screening Section. If further sickle cell testing is appropriate, a capillary blood sample may be mailed to the Sickle Cell Disease Association of America, Michigan Chapter (SCDAA-MI). Tubes, forms, and envelopes may be obtained from SCDAA-MI. (Refer to the Directory Appendix for contact information.)

9.2 NEWBORN BILIRUBIN

A universal predischarge newborn bilirubin screening (measurement and assessment of clinical risk factors) is to be performed using total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) measurements to evaluate the risk of subsequent severe hyperbilirubinemia as recommended by the AAP periodicity schedule. The PCP should confirm initial screening was accomplished, verify the results, and follow-up as appropriate.

9.3 CRITICAL CONGENITAL HEART DEFECT SCREENING

A critical congenital heart defect (CCHD) screening is to be administered to the newborn child as indicated by the AAP periodicity schedule. The screening should not be performed until 24 hours after the birth of the child and should be performed as late as possible if an early discharge is planned in order to reduce the number of false positive results. The screening should be performed with motion-tolerant pulse oximeters using either disposable or reusable pulse oximetry probes.

Oxygen saturations should be obtained from the right hand and one foot. Screening that has a pulse oximetry reading of ≥95% in either extremity with a ≤3% absolute difference between the upper and lower extremity is considered a passing result. It is recommended that repeated measurements be performed in those cases in which the initial screening result was positive in an effort to reduce false-positive results. Infants with saturations <90% should receive an immediate evaluation. It is important to note that the oxygen saturation thresholds for a positive screening result may vary at high altitude. If the screening is positive, CCHD needs to be excluded with a diagnostic echocardiogram. Infectious and pulmonary causes of hypoxemia should also be excluded. Every hospital is required to report each newborn's pulse oximetry screening results to the Newborn Screening Program. (Refer to the Directory Appendix for contact information.)

9.4 IMMUNIZATIONS

A review of immunization status shall be performed at each well child visit, with immunizations administered according to recommendations and standards of practice recognized by the AAP and the Advisory Committee on Immunization Practices (ACIP). Providers are reminded that all immunizations must be reported to the Michigan Care Improvement Registry (MCIR). (Refer to the Directory Appendix for contact information.) Vaccine counseling services, including stand-alone vaccine counseling services, are covered for all Medicaid beneficiaries when they are counseled regarding the importance of vaccines.

Stand-alone vaccine counseling refers to when a beneficiary and/or caregiver receives counseling about a vaccine from a health care practitioner, but the beneficiary does not actually receive the vaccine on the same date of service as the counseling.

Immunizations are covered when administered according to ACIP recommendations. MDHHS encourages providers to immunize all Medicaid beneficiaries.

- For Medicaid eligible children 18 years of age and younger, the Vaccines for Children (VFC) Program provides covered immunizations at no cost to the provider.
- Medicaid covers immunizations for beneficiaries 19 years of age and older.
- Any LHD in the state can be contacted for specifics about the VFC program.

For immunizations available free of charge under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is $5.00, then the charge for immunization administration to the Medicaid beneficiary cannot exceed $5.00.

Medicaid Health Plan (MHP) providers enrolled in the VFC program are encouraged to immunize and are discouraged from referring beneficiaries to a LHD for these services. (Refer to the Practitioner Chapter for additional information.)

9.5 Anemia

The PCP must screen the child for anemia according to the AAP periodicity schedule.

9.6 Blood Lead Screening

All children covered by Medicaid are considered at high risk for blood lead poisoning. The AAP periodicity schedule requires children to be tested for blood lead poisoning at 12 and 24 months of age. In addition, the Centers for Medicare & Medicaid Services (CMS) mandates that if a child is covered by Medicaid, is between 36 and 72 months of age, and has not been tested for blood lead, the child must be tested. The AAP also requires a blood lead risk assessment to be performed during specific visits as indicated by the AAP periodicity schedule. If the parent/guardian is unsure if the child was previously tested, the child must be tested.

For children who have been tested, the following questions are intended to assist the PCP in determining if further testing is necessary in addition to that completed at the mandated ages:

- Does the child live in or regularly visit a home built before 1978? (Note: Recent or planned renovations can greatly increase risk of lead exposure in homes built before 1978.)
- Does the child live in or regularly visit a home that had a water test with high lead levels?
- Does the child have a brother, sister, or friend that has an elevated blood lead level?
- Does the child come in contact with an adult whose job or hobby involves exposure to lead (e.g., smelting, indoor shooting/firing ranges, pottery, stained glass, refinishing old furniture)? (The chart following these questions presents examples.)

- Does the child's caregiver use home remedies that may contain lead (e.g. ba-baw-san, daw tway, greta, azarcon, balguti kesaria, ghasard)? (The chart following these questions presents examples.)
- Is the child in a special population group such as foreign adoptee, refugee, migrant, immigrant, or foster child?
- Does the child's caregiver have reason to believe the child is at risk for lead exposure (e.g., exhibiting pica behavior, developmental delays)?

If answered "yes" or "don't know" to any of these questions, lead testing is recommended.

Possible means of exposure to lead hazards:

Occupational	Hobbies	Environmental	Other
▪ Battery manufacturing or repair ▪ Bridge reconstruction worker ▪ Chemical manufacturing ▪ Construction worker ▪ Glass manufacturing ▪ Industrial machine operator ▪ Migrant farm worker ▪ Painting ▪ Plastics manufacturing ▪ Plumber, pipe fitter ▪ Police officer ▪ Printing ▪ Radiator repair ▪ Rubber products manufacturing ▪ Steel welding and cutting ▪ Vehicle repair	▪ Brass/copper/aluminum processing ▪ Casting lead figures (e.g., toy soldiers) ▪ Furniture refinishing ▪ Jewelry and pottery making ▪ Lead soldering (e.g., electronics) ▪ Making lead shot, fishing sinkers, bullets ▪ Painting ▪ Stained glass making ▪ Target shooting at firing ranges ▪ Vehicle repair	▪ Burning lead-painted wood ▪ Ceramic ware/pottery ▪ Lead crystal ▪ Lead-soldered cans (imported) ▪ Lead paint ▪ Lead-painted homes ▪ Living near lead-related industries ▪ Renovating/remodeling older homes ▪ Soil/dust near industries and roadways ▪ Use of water from lead pipes	▪ Cosmetics (e.g., Kohl, sindoor) ▪ Food/spices and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandu, Xyoo- Fa, Mai ge fen, poying tan, lozeena, turmeric, hot sauce, some Mexican candy)

Publications and other materials concerning blood lead may be obtained from the MDHHS Childhood Lead Poisoning Prevention Program. The MDHHS Bureau of Laboratories – Trace Metals Section can also be contacted. (Refer to the Directory Appendix for contact information.)

There are providers in all areas of the state who have expertise in the treatment of blood lead and are available to discuss blood lead issues with other providers. Providers with questions concerning blood lead testing or treatment should contact the Childhood Lead Poisoning Prevention Program to obtain contact information for these providers. (Refer to the Directory Appendix for contact information.)

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the MDHHS Bureau of Laboratories – Trace Metals Section or to any Michigan Medicaid-enrolled laboratory qualified to perform blood lead testing. If the MDHHS Bureau of Laboratories – Trace Metals Section is used, blood lead testing supplies may be obtained from the laboratory. (Refer to the Directory Appendix for contact information.)

Michigan has an established statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere).

- If blood lead samples are sent to the MDHHS Bureau of Laboratories – Trace Metals Section:
  - Providers must obtain a Submitter Clinic Code prior to sending blood lead samples. Providers may obtain a Submitter Clinic Code by contacting the MDHHS Bureau of Laboratories – Data and Specimen Handling (DASH) Unit. (Refer to the Directory Appendix for contact information.)
  - The "Blood Lead Test Requisition" form (DHHS-0696) must be used. (The form is available on the MDHHS website. Refer to the Directory Appendix for website information.)
- If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, the provider must include the following:
  - information with respect to the individual tested (name, sex, ethnicity, race, birthdate, address (and, to the extent available, whether the residence or property is owned or rented), telephone number, Medicaid number, parent/guardian (if individual is a minor), employer (if individual is an adult), secondary contact (name and phone number) for individual tested or parent/guardian;
  - date of the sample collection;
  - the type of sample (capillary or venous); and
  - provider's name, name of practice (if applicable), telephone number, fax number, e-mail address, and mailing address.

  When testing is completed, the laboratory completes the required information and submits it to the blood lead registry.

PCPs are encouraged to draw blood in their offices for all children needing blood lead testing, but may refer children to a lab if necessary. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the LHD agrees to obtain a blood sample for blood lead testing, the PCP may refer a child to the LHD for the service. (Refer to the Local Health Department Chapter for additional information.)

The MDHHS Bureau of Laboratories – Trace Metals Section will report all results to the child's ordering provider. All clinical laboratories in Michigan that analyze blood samples for lead shall report all blood lead results to the MDHHS Childhood Lead Poisoning Prevention Program/Community Public Health

Agency (CLPPP/CPHA). Reports shall be made within five working days after test completion. If a blood lead test has been completed but is not displayed in the MCIR, the LHD or PCP should contact the MDHHS CLPPP to report the blood lead results. (Refer to the Directory Appendix for contact information.)

There is no established safe level of lead for children. While the below recommendations indicate that certain actions should begin at a blood lead reference value (BLRV) of 3.5 µg/dL, providers may use their own clinical judgement in determining the appropriate actions in the medical management of children potentially exposed to lead whose blood lead levels are below this level. These activities may include, but are not limited to, repeat testing, follow-up evaluations, treatment services, referral for nurse case management services through the local health department, and referral for environmental investigation.

Recommendations on Medical Management of Childhood Lead Exposure and Poisoning*

Blood Lead Level	Action
< 3.5 µg/dL	▪ The limit of detection for lead can vary by lab and is typically between 1 and 3.3 µg/dL. ▪ Review laboratory results with the family. For reference, the geometric mean BLL for children 1-5 years old in the United States is less than 1 µg/dL. Emphasize with the family the dangers of lead and the need for vigilance. ▪ Repeat the BLL in 6-12 months if the child is at high risk or if the environmental risk changes during the timeframe. Ensure lead testing is done at 1 and 2 years of age and thereafter, based on local and state guidelines. ▪ For children tested at age <12 months, consider re-testing in 3-6 months, as lead exposure may increase as mobility increases. Consider lead-contaminated tap water used daily for infant formula as a possible significant source that may be missed in later assessments of BLL. ▪ Perform routine health maintenance, including assessment of nutrition, physical and mental development, as well as iron deficiency risk factors, as per the recommendations in the AAP Bright Futures Guidelines. ▪ Provide preliminary advice about reducing/eliminating exposures (e.g., wash children's hands/toys frequently; damp-mop floors, windows and windowsills; leave shoes at the home's threshold; place duct tape or contact paper over chipping/peeling paint; avoid renovations that may create a dust hazard).
3.5-14 µg/dL	▪ Perform steps as described above for levels <3.5 µg/dL. ▪ Re-test venous BLL within 1-3 months to ensure the lead level is not rising. If it is stable or decreasing, re-test the BLL in 3 months. Refer patient to the local health department (LHD). Contact the MDHHS Childhood Lead Poisoning Prevention Program, the Centers for Disease Control and Prevention (CDC), the National Lead Information Center, or the national Pediatric Environmental Health Specialty Unit (PEHSU) network for resources regarding lead-poisoning prevention. (Refer to the Directory Appendix for contact information.) ▪ Take a careful environmental history to identify potential sources of exposure. Consider young siblings and other children who may be exposed. If lead paint in older homes is the exposure concern, advise that lead paint abatement is the best solution, and refer the family to the LHD for resources and information.

Recommendations on Medical Management of Childhood Lead Exposure and Poisoning*

Blood Lead Level	Action
	▪ Provide nutritional counseling related to calcium, vitamin D, and iron. In addition, recommend having fruit at every meal, as iron absorption quadruples when taken with vitamin C-containing foods. Encourage the consumption of iron-enriched foods (e.g., cereals, meats). Some children may be eligible for Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) or other nutritional resources. ▪ Ensure iron sufficiency with adequate laboratory testing (complete blood count [CBC], ferritin, and reticulocyte count) and treatment per AAP guidelines. Consider starting a multivitamin with iron or iron supplementation as indicated. ▪ Perform structured developmental screening evaluations at child health maintenance visits per recommendations in Bright Futures Guidelines and, if indicated, refer to therapeutic and special educational programs (e.g., Early Intervention Program or Individualized Education Plan) as lead effect on development may manifest over years.
15-44 µg/dL	▪ Perform steps listed above for levels 3.5-14 µg/dL. Report results to the LHD. ▪ Determine if there are any symptoms which may be subtle and can include anorexia and abdominal discomfort. ▪ Confirm BLL with venous sample within 1 to 2 weeks, or more rapidly for higher levels. ▪ Work with the family to identify and remove potential lead sources. Refer to the LHD to conduct home investigation to assess for the lead source. ▪ Additional specific evaluation of the child, such as an abdominal x-ray, should be considered based on the environmental investigation and history (e.g., pica for paint chips, mouthing behaviors). Gastrointestinal decontamination may be considered if radio-opaque foreign bodies consistent with ingested lead are visualized on x-ray. Any treatment for BLL in this range should be done in consultation with an expert. ▪ Contact your regional PEHSU or the Michigan Poison and Drug Information Center (MiPDC) for guidance. (Refer to the Directory Appendix for contact information.)
>44 µg/dL	▪ Follow above guidance for BLL 15-44 µg/dL. Report results to state and local health authorities. ▪ Confirm the BLL with repeat venous lead level within 48 hours, or more rapidly for higher levels. ▪ Obtain a CBC, electrolytes, blood urea nitrogen, creatinine, liver transaminase enzyme levels, and urinalysis in anticipation of chelation therapy. ▪ Abdominal x-ray should be done to look for radio-opaque foreign bodies suggestive of recent ingestion as this may change management. Consider gastrointestinal decontamination if radio-opaque foreign bodies consistent with ingested lead are visualized on x-ray.

Recommendations on Medical Management of Childhood Lead Exposure and Poisoning*

Blood Lead Level	Action
	▪ Emergently admit all symptomatic children to a hospital. If there is evidence of significant central nervous system pathology, consider pediatric intensive care unit admission. If asymptomatic, consider hospitalization and/or chelation therapy (managed with the assistance of an experienced provider). Chelation in the context of ongoing exposure is ineffective and may result in increasing lead levels in the central nervous system. Factors that may influence management include the status of the home with respect to lead hazards, ability to isolate the lead source, family social situation, and chronicity of the exposure. An elevated blood zinc-protoporphyrin level (ZPP) can confirm either an iron-deficiency anemia as a comorbidity in the lead-poisoned child or, if there is no iron deficiency present, a more chronic lead exposure. Contact your regional PEHSU or MiPDC for assistance. (Refer to the Directory Appendix for contact information.) ▪ Prior to initiating chelation therapy for outpatient therapy, it is critical that the home environment is inspected, temporary mitigation measures applied, and preferably demonstration of stable or down-trending lead levels indicating the primary source of lead exposure has been removed prior to starting chelation therapy. There is a risk of worsening lead exposure if chelation therapy continues in a residence with persistent lead hazards. It is expected, after a course of chelation therapy, that the BLL will rebound as the lead re-equilibrates. After chelation is completed, continue to follow the child until the BLL declines steadily; consider occurrence of re-exposure if the BLL remains stable or rebounds above pre-chelation levels.

* Notes:

- Table and recommendations adopted from the AAP and the PEHSU.
- No level of lead in the blood is safe.

9.7 Tuberculosis Testing

Medicaid covers tuberculosis (TB) testing according to the AAP periodicity schedule, and upon the recognition of high risk factors. Coverage for the TB test includes any return visit to read the results of the TB test. A risk assessment must be completed at each well child visit. Mantoux testing is the preferred testing method. For assistance in determining high risk and testing, providers may refer to the AAP Red Book: Report of the Committee on Infectious Diseases, or contact the MDHHS Division of Communicable Diseases and/or the Division of Immunization. (Refer to the Directory Appendix for contact information.)

9.8 Dyslipidemia Screening

All children and adolescents should undergo a dyslipidemia (cholesterol) screening once between 9 and 11 years of age and once between 17 and 21 years of age. For children with a significant family history or other risk factors, a lipid assessment should be considered as early as 2 years of age. If a family history cannot be ascertained and other risk factors exist, testing is at the provider's discretion. The lipid assessment should include a fasting or non-fasting lipid profile. Children and adolescents identified as being high risk should be counseled on lifestyle changes in an effort to reduce the risk of Cardiovascular

Disease (CVD). Children younger than 10 years of age should not be treated with medication unless they have a severe hyperlipidemia or a high-risk condition that is associated with serious medical morbidity. Decisions regarding the need for medication therapy should be based on the average of results from two fasting lipid profiles obtained at least two weeks but no more than three months apart.

9.9 Sexually Transmitted Infections (STI)

A risk assessment for sexually transmitted infections (STIs) is to be performed annually for all sexually active individuals beginning at 11 years of age as recommended by the AAP periodicity schedule. Adolescents and children should be fully immunized, screened for risk, and appropriately tested and treated for STIs. It is recommended to screen males who have sex with males (MSM) at least annually for STIs, and screen every three to six months if the male adolescent is considered high risk because of multiple or anonymous partners, having sex in conjunction with illicit drug use, or having sex partners who participate in these activities.

9.10 Human Immunodeficiency Virus (HIV) Screening [Change Made 7/1/2025]

A risk assessment for the human immunodeficiency virus (HIV) is to be performed annually for children beginning at 11 years of age and as recommended by the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 15 and 21 years of age, making every effort to preserve confidentiality of the adolescent and the young adult. After initial screening, youth at increased risk of HIV infection should be retested annually or more frequently. The PCP should verify the results, follow-up, and refer as appropriate. **(text revised per bulletin MMP 25-11)**

9.11 Hepatitis B Virus Infection

A risk assessment for hepatitis B virus (HBV) infection is to be performed for children from newborn to 21 years of age as indicated by the AAP periodicity schedule, according to recommendations per the United States Preventive Services Task Force (USPSTF) and the 2021-2024 edition of the AAP Red Book: Report of the Committee on Infectious Diseases. These screenings, provided for individuals under 21 years of age, are considered an EPSDT service. An HBV infection screening may be provided to any individual requesting the screen, regardless of their disclosure of risk, since there may be reluctance to disclose these risks.

Screening for hepatitis B should be performed with Hepatitis B Surface Antigen (HBsAg) tests approved by the U.S. Food and Drug Administration (FDA), followed by a confirmatory test for initially reactive results. Serologic panels performed concurrently with or after HBsAg screening aid in facilitating the diagnosis and to determine further management.

Individuals who test positive for an HBV infection generally receive education regarding reducing the risk of transmission to others (e.g., during childbirth or with sex and needle-sharing partners and household contacts). EPSDT services include the coverage of any follow-up services and referrals that are medically necessary to treat an HBV infection. Individuals with HBV infection should be provided information about treatment options, how to prevent transmission of HBV to others, and drug treatment, as appropriate. Every effort should be made to preserve the confidentiality of the patient.

9.12 Hepatitis C Virus (HCV) Infection Screening

All individuals should be screened for a hepatitis C virus (HCV) infection at least once between 18 and 79 years of age. These screenings, provided for individuals under 21 years of age, are considered an EPSDT service. Individuals at increased risk of HCV infection, including those with past or current injection drug use, should be tested for HCV infection and reassessed annually. An HCV infection screening may be provided to any individual requesting the screen regardless of their disclosure of risk since there may be reluctance to disclose these risks.

For individuals identified with HCV infection, it is recommended that they receive appropriate care, including HCV clinical preventive services (e.g., screening and intervention for alcohol or drug use, hepatitis A and hepatitis B vaccination, and medical monitoring of disease). EPSDT services include the coverage of any follow-up services and referrals that are medically necessary to treat an HCV infection. Individuals with HCV infection should be provided information about treatment options, how to prevent transmission of HCV to others, and drug treatment, as appropriate.

9.13 Sudden Cardiac Arrest and Sudden Cardiac Death

Assessing for risk of sudden cardiac arrest (SCA) and sudden cardiac death (SCD) is to be performed as appropriate from 11 to 21 years of age and as indicated by the AAP periodicity schedule. The AAP recommends screening children for SCA and SCD by asking four questions whereas a positive response may indicate an increased risk for SCA and SCD. The PCP may find a positive response to be a significant cue to perform a cardiovascular evaluation which may occur at their discretion.

It is recommended that SCA and SCD screening should be performed for all children regardless of their athletic participation. The screening should be performed at the same time as the pre-participation examinations, at a minimum of every three years, or on entry into middle or junior high school and into high school. Depending on family and PCP concerns, more frequent screening may be appropriate. The four questions that may be applied directly to a family questionnaire are as follows:

- Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises such as doorbells, alarm clocks, and ringing telephones?
- Have you ever had exercise-related chest pain or shortness of breath?
- Has anyone in your immediate family (parents, grandparents, siblings) or other more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or Sudden Infant Death Syndrome (SIDS).
- Are you related to anyone with hypertrophic cardiomyopathy or hypertrophic obstructive cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator?

A positive response from these four questions, or an abnormal electrocardiogram (ECG), should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist.

9.14 Cervical Dysplasia Screening, Breast Exams, Counseling and Risk Factor Interventions

Screening for cervical cancer in females younger than 21 years of age is not recommended unless a patient has an immune suppression or infection with HIV, in which case an annual Pap test should be administered with the onset of sexual activity. Females previously screened who had a documented cervical intraepithelial neoplasia (CIN) 2 or 3 or carcinoma will require continued screening. Clinical breast exams and the teaching of breast self-examinations for women younger than 21 years of age is not recommended as part of the routine physical examination; breasts should be examined in the female adolescent as part of the assessment of sexual maturity and in the male adolescent to observe for gynecomastia. Whenever a screening for cervical dysplasia as part of a pelvic examination and Pap smear is provided, a breast exam, counseling, and risk factor interventions must be provided.

9.15 Diabetes (Type 2)

High-risk children must be tested according to the AAP periodicity schedule. Beginning at 10 years of age (or at the onset of puberty if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested in accordance with the AAP periodicity schedule guidelines.

A child is considered high risk if they are overweight (i.e., BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120 percent of ideal for height) and have any two of the following factors:

- A family history of Type 2 diabetes in first- and second-degree relatives;
- Belongs to a certain race/ethnic group (e.g., Native American, African-American, Hispanic, Asian/Pacific Islander); or
- Signs of insulin resistance or conditions associated with insulin resistance (e.g., acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).

SECTION 10 – ORAL HEALTH

The dental health of the beneficiary begins with an oral health screening and caries risk assessment by the child's PCP for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted or not. MDHHS requires providers to stress the importance of preventive and restorative dental care. Encourage parents/caregivers to brush their child's teeth as soon as teeth erupt with fluoride toothpaste in the proper dosage appropriate for the child's age. Children should be referred to establish a dental home when the first tooth erupts and as recommended by the AAP periodicity schedule. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the PCP should continue to perform an oral health risk assessment during each well-child visit. The PCP should follow-up, educate, and refer as appropriate. Refer to the Directory Appendix for website information on the American Academy of Pediatric Dentistry (AAPD) Caries Risk Assessment Tool. A separate periodicity schedule for dentists is established. The Dental Periodicity Schedule follows the AAPD Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. Refer to the Dental chapter of the Medicaid Provider Manual for additional information.

10.1 FLUORIDE VARNISH

The PCP is to apply fluoride varnish, with parent or caregiver approval, to the primary teeth of all infants and children starting at the age of primary tooth eruption and until the establishment of a dental home. Once teeth are present, apply fluoride varnish to all children every three to six months in the primary care or dental office based on caries risk until six years of age as indicated by the AAP periodicity schedule.

The AAP recommends that providers receive additional training on oral screenings, fluoride varnish indications and application, and office implementation. Additional training on oral screenings, fluoride varnish indications and application, and office implementation can be found in the Smiles for Life Curriculum Course: Caries Risk Assessment, Fluoride Varnish and Counseling. Providers and staff are encouraged to complete the online training module and obtain certification prior to providing oral health screenings and fluoride varnish applications. (Refer to the Directory Appendix for website information.)

10.2 FLUORIDE SUPPLEMENTATION

The PCP should consider oral fluoride supplementation as recommended by the AAP periodicity schedule if the primary water source is deficient in fluoride. It is important to consider a child's overall systemic exposure to fluoride from multiple sources (e.g., water fluoridation, toothpaste, supplements, and/or varnish) prior to prescribing fluoride supplements to minimize the risk of mild fluorosis.

SECTION 11 – ANTICIPATORY GUIDANCE

Anticipatory guidance provided by the AAP explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's/adolescent's life. Anticipatory guidance gives the PCP, parent(s)/guardian(s), and the child/adolescent an opportunity to ask questions and to discuss issues of concern. Anticipatory guidance focuses on five priority areas including physical growth and development, social and academic competence, emotional well-being, risk reduction, and violence and injury prevention. The PCP is encouraged to inquire about these priority areas, and to adapt questions and discussion points to meet the specific needs of the families and communities to whom they provide care.

An interpretive conference should also be included to explain the results of the well child visit. Depending on the age and/or family status of the child/adolescent, the conference may be held directly with the child/adolescent, the child/adolescent and parent/guardian, or only with the parent/guardian. If a child/adolescent has a potential or apparent abnormality, the PCP is responsible for providing, or referring for, follow-up diagnostic services and treatment.

11.1 SLEEP POSITION COUNSELING

Positioning of infants on their backs on a firm sleep surface and discussing recommendations for creating a safe sleeping environment with the parent(s)/guardian(s) must occur at each well child visit through 12 months of age. Infants should be placed on their back unless a medical condition warrants that a provider recommends otherwise after weighing the relative risks and benefits. (Refer to the Maternal-Child Educational Resources portion of the Directory Appendix for additional sources regarding infant sleep positioning and to the AAP for recommendations for a safe infant sleeping environment.)

11.2 NUTRITIONAL ASSESSMENTS

Age-appropriate nutrition counseling must be provided at each well child visit. Nutritional assessments must be based on:

- Height, weight, and their relatedness;
- The most recent hematocrit/hemoglobin value;
- Physical examination; and
- Health history.

11.3 VIOLENCE AND INJURY PREVENTION

Violence and injury prevention must be discussed at each well child visit. Providers should become familiar with Connected Kids: Safe, Strong, Secure, the AAP's primary care violence prevention protocol. This resource gives providers recommendations and resources to incorporate preventive education, screening for risk, and linkages to community-based counseling and treatment resources. Treatment and/or a referral for violence and injury related problems identified should be appropriate and timely. (Refer to the Provider Resources portion of the Directory Appendix for additional sources regarding youth violence and injury.)

SECTION 12 – CHILDREN IN FOSTER CARE

Medical interventions, screenings, and various preventive health care services are to be up-to-date for all children in foster care. For purposes of this section, any reference to "child" or "children" in foster care includes any individual in foster care who is younger than 21 years of age. The care of children should be comprehensive, well-coordinated, and fully documented throughout their stay in foster care. All children in foster care younger than 21 years of age must receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 days of entering foster care. All children in foster care are eligible for Medicaid from the first day of the month of entry into foster care. The PCP must verify the child in foster care's eligibility and enrollment status. In case of difficulty confirming Medicaid status, or of verifying Medicaid Health Plan enrollment, the PCP should contact the foster care worker or the local MDHHS office designee. The PCP must complete the health maintenance visit regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system.

The PCP's office staff should obtain the completed MDHHS "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment" form (DHS-3762) from the foster care parent, or consent from the child in foster care if the child is at least 18 years of age, before the child is seen by the PCP. This form provides the PCP with informed consent to routine, non-surgical medical care and emergency medical or surgical treatment and provides the child's foster care worker's or local MDHHS office designee's contact information. This form does not grant informed consent for the physician to provide psychotropic medication treatment. The MDHHS "Psychotropic Medication Informed Consent" form (DHS-1643) must be completed to receive informed consent to provide psychotropic medication treatment. (Refer to the MDHHS website for copies of forms and form information. Refer to the Directory Appendix for website information.)

A child may be assigned to a new PCP upon entry into the foster care system, and it will be necessary for the child's previous PCP to share the child's health information with the new PCP. In an order placing a child in foster care, the court shall include an order that each of the child's medical providers release the child's medical records. The court order requires the parent(s) to provide names and contact information for all previous medical and mental health providers, and to sign a consent to release health information on the day of the court proceedings.

The supervising agency shall develop a medical passport for each child who comes under its care. The medical passport shall contain all medical information required by policy or law to be provided to the PCP and to the foster care parent. The medical passport includes a basic medical history, a record of all immunizations from the Michigan Care Improvement Registry (MCIR), a complete and regularly updated statement of medical appointments, prescribed medications, and any other information available to the foster care worker concerning the child's medical, physical, and mental health status. The medical passport should be shared with the child's foster care parents and all medical providers even if the document is not complete or up to date. Updates to the medical passport should be shared with the foster care parents and medical providers when new information becomes available. If health information, including the medical passport, is not made available to the medical provider at or before the time of the medical examination, the medical provider should contact the foster care worker and/or the local MDHHS office designee (noted on the DHS-3762 form) to assist with obtaining the missing health information.

The medical evaluation must follow the AAP periodicity schedule and Medicaid EPSDT policy. The examination should be completed according to the recommendations for the nearest or most appropriate periodic examination age. The PCP will assess the child for medical, dental, developmental, and mental

health needs. The full medical evaluation will include an immunization review, health history, and physical examination. The medical examination and screenings should be documented for the initial and for all subsequent well child visits and will become a part of the child's medical record. PCPs may reference the age appropriate MDHHS Well Child Exam form and use their own Well Child Exam form or electronic medical record (EMR) if the form or EMR contains all of the elements of the AAP periodicity schedule. (Refer to the Directory Appendix for AAP and MDHHS website information.)

The dental examination must follow the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. (Refer to the Directory Appendix for AAPD website information.) The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease. Refer to the Dental chapter of the Medicaid Provider Manual for additional information.

A developmental/behavioral assessment must be completed according to the recommendations of the AAP. A developmental/behavioral assessment includes developmental screening; autism spectrum disorder screening; developmental surveillance; behavioral/social/emotional screening; tobacco, alcohol or drug use assessment; and depression screening. Screening for these potential developmental/behavioral issues is accomplished by using an objective validated and standardized screening tool and should be completed with the assistance of a person who knows the child best. This may be the child's biological parent, foster care parent, caregiver, or other adult who knows the child. The foster care worker is available to assist the provider in identifying the person who knows the child best. The behavioral/social/emotional screening is required at each scheduled well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the ASQ-SE or PSC with appropriate action to follow if the assessment is positive. PCPs should use a validated and standardized screening tool for all children in foster care and for children with mental health conditions. The use of validated and standardized screening tools improves the detection rate of social-emotional problems of children in foster care compared to the reliance on subjective clinical judgment (i.e., surveillance).

The foster care worker is trained in the use of the ASQ-SE and PSC. If the physician chooses to use either of these tools, the foster care worker is available to assist in completing the screening tool and ensure that it is made available to the medical provider for scoring and for incorporation into the treatment plan. The individual accompanying the child to the medical examination should present the completed screening tool to the PCP at the initial appointment or for any other periodic examinations. The PCP is responsible for scoring and interpreting the results of the screening tool and proposing recommendations regarding follow-up. (Refer to the Directory Appendix for foster care resources.)

The PCP will recommend to the foster care worker, the birth parents, and the foster care parents (when applicable) when the child in foster care may benefit by visiting with a mental health professional. The child will be referred for a prompt follow-up assessment by an appropriate medical, dental, developmental, or mental health professional for any further identified health needs. For more information, refer to the Developmental/Behavioral Assessment Section of this chapter.

12.1 Psychotropic Medication Treatment

A psychiatric diagnosis using the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) must be made before prescribing psychotropic medications to any child in foster care. When the physician determines that the child requires psychotropic medication treatment, the prescribing physician must

obtain a written and signed informed consent from the child's legal parent (when the child is a temporary court ward), the child (if the child is at least 18 years of age), the foster care worker (when the child is a ward of the state and is committed to the Michigan Children's Institute), or the court (when the child is a permanent court ward of the county) before treatment with any psychotropic medication begins. If a signed informed consent cannot be obtained (e.g., the parent is unable or unwilling to sign, and the physician documents a medical necessity), a court order is required prior to prescribing psychotropic medications to any child in foster care. Foster care parents cannot consent to administration of psychotropic medication. For questions regarding who may provide consent for treatment with psychotropic medications, the physician may contact the child's foster care worker.

Informed consent must be documented by completion of the MDHHS "Psychotropic Medication Informed Consent" form (DHS-1643). (MDHHS forms are available on the MDHHS website. Refer to the Directory Appendix for website information.) Informed consent includes an explanation from the prescribing physician regarding the child's diagnosis, proposed treatment, expected outcomes, any side effects, risks involved, discussion of laboratory findings and ongoing monitoring, uncommon but potentially severe adverse events, a discussion of alternative treatments, the risks associated with no treatment, and the overall potential benefit-to-risk ratio of treatment. If consent is denied by the child's birth parent or legal guardian, or the consent cannot be obtained, a court order shall be obtained by the foster care worker to authorize the administration of the psychotropic medication to the child held in legal custody based on the physician's attestation that treatment with psychotropic medication is medically necessary. If a child is prescribed psychotropic medication prior to enrollment in the foster care system, the DHS-1643 must be completed within 45 days of a child's entry into the foster care system to assure uninterrupted psychotropic medication treatment. The child in foster care who is at least 18 years of age is able to consent to and/or refuse medical treatment. A new DHS-1643 will be required if there is a new psychotropic medication prescribed, a discontinuation of the psychotropic medication, a change in dosage that exceeds the limits of the provided consent, or if the child is at least 18 years of age. The DHS-1643 must be renewed annually.

12.2 Enrollment and Billing

MDHHS has designated a Health Liaison Officer (HLO) or an HLO point person to every county in Michigan to assist children in foster care with health plan enrollment/disenrollment, facilitate the timely completion of an initial medical examination, and generally provide technical support to foster care workers. Until HLO positions are allocated for complete statewide coverage, each local MDHHS office has an assigned supervisor to serve as the point person for obtaining any health-related information or for resolving health-related issues.

All children placed into foster care must receive an EPSDT comprehensive examination within 30 days of entering foster care regardless of when their most recent exam was provided. PCPs may complete and bill for an EPSDT/preventive health care well child visit for any child who must be seen within 30 days of entering the foster care system, and for any additional follow-up visits the PCP believes are necessary. The PCP may bill for the visit even if the child in foster care received a recent preventive health care service prior to entry into the foster care system. The PCP should screen all children for developmental and behavioral concerns using a validated and standardized screening tool as indicated by the AAP periodicity schedule. (Refer to the Developmental/Social/Behavioral/Mental Health section of this chapter for additional information.)

Children in foster care not enrolled with a health plan by the time a full medical examination is provided within the 30 day requirement will be considered Fee for Service (FFS). Children in foster care residing in detention facilities, child care institutions, or out-of-state placements will be considered FFS and will not

be transitioned to a health plan. PCPs must verify eligibility and enrollment status prior to providing services to children in foster care. If the child in foster care is enrolled in an MHP, prior authorization requirements may apply.

SECTION 13 – REFERRALS

If a medical issue is determined or suspected during a well child visit, the (suspected) issue must be diagnosed and treated as appropriate. This determination may result in a referral to another provider or a self-referral for further diagnosis and treatment. Referrals must be made based on standards of good practice and the AAP Recommendations for Preventive Pediatric Health Care or presenting need, if outside the normal schedule.

When a FFS provider performs medically necessary treatment involving diagnostic or therapeutic procedures for a medical condition found during a well child visit (e.g., wart removal), these procedures are covered in addition to the well child visit. For information regarding billing a well child evaluation and management (E/M) visit and other E/M visits occurring on the same date of service, refer to the Evaluation and Management Services Section of the Practitioner Chapter. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If providers are not familiar with other providers in the area, the LHD can be of assistance with referrals. MHP providers must follow the referral procedures for the specific health plan in which the beneficiary is enrolled.

13.1 PSYCHIATRIC SERVICES

Psychiatric services are available for Medicaid FFS beneficiaries younger than 21 years of age with mild/moderate mental health conditions or suspected behavioral disorders. (Refer to the Behavioral Health and Substance Use Disorder Services subsection of the Practitioner Chapter for specific coverages.) MHP contracts include mental health benefit coverage for beneficiaries with mild/moderate mental health conditions.

PIHPs/Community Mental Health Services Programs (CMHSPs) are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries who have more significant and/or complex psychiatric conditions.

13.2 AUTISM SPECTRUM DISORDERS

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the PIHP directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for information/policy regarding the treatment of children with autism.)

13.3 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program is located in each county in Michigan at LHDs, Tribal Health Centers, and federally funded clinics. WIC is a special health and nutrition program that has demonstrated a positive effect on pregnancy outcomes and child growth and development. WIC provides supplemental healthy foods, nutrition counseling and education, breast feeding support, immunization screening, and referrals to other helpful services to pregnant women, breastfeeding and post-partum women, infants, and children younger than 5 years of age. The PCP is expected to make referrals to a WIC site for eligibility determination if appropriate. (Refer to the Directory Appendix for website and contact information.)

13.4 Pediatric Outpatient Intensive Feeding Program Services

Pediatric outpatient intensive feeding program services are for beneficiaries with significant feeding and swallowing difficulties. Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. The child should be referred to a CSHCS-approved, Medicaid-enrolled program site that is certified by MDHHS. (Refer to the Pediatric Outpatient Intensive Feeding Program Services Section of the Special Programs Chapter for additional information.)

13.5 Blood Lead Poisoning Follow-Up Services

Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and case management services. The PCP must contact the LHD to determine if blood lead services are available in the area and the blood lead levels at which referrals are accepted. In locations where LHDs do not provide this service, the MDHHS Healthy Homes Section can be contacted to perform the environmental investigation. (Refer to the Additional Information on Blood Lead Testing Section of the Local Health Departments Chapter for additional information and to the Directory Appendix for contact information.)

The PCP may refer pregnant women and children who were served by the Flint water system to the Genesee Health System, the local community mental health (CMH) serving Genesee County that serves as the Designated Provider Organization (DPO), for any needed Family Supports Coordination services. (Refer to the Special Programs Chapter, Flint Family Supports Coordination Services Section, for additional information.)

13.5.A. Environmental Investigations

An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. (Refer to the Local Health Departments Chapter for additional information on blood lead testing and follow-up services.)

13.5.B. Case Management Services

Case management services for children with a BLRV of 3.5 µg/dL or greater are covered under the CSHCS case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)

13.5.C. Blood Lead Resource Documents

Providers are encouraged to obtain and review materials and resources concerning blood lead poisoning from the MDHHS Childhood Lead Poisoning Prevention Program. (Refer to the Directory Appendix for contact information.)

13.6 Other Programs

There are other programs that could benefit Medicaid beneficiaries such as Head Start, intermediate school district/regional education service agency services, genetics counseling, nutrition programs, and public health nursing. Providers are encouraged to become familiar with available programs and make full use of the programs whenever referrals are appropriate.

SECTION 14 – OUTREACH

MDHHS provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts.

When the beneficiary's **mihealth** card is issued, it is mailed with the MDHHS publication "Michigan Free Health Check-Ups." The publication explains the benefits of a well child visit, describes procedures included in the free health check-up, and presents information about medical transportation options available to beneficiaries for travel to and from well child visits.

Soon after the **mihealth** card is issued, the beneficiary will receive a monthly outreach list, a letter that stresses the importance of well child visits, and medical transportation information.

14.1 FEE-FOR-SERVICE (FFS)

For beneficiaries younger than 2 years of age, a letter stressing the importance of well child visits is sent to the parent/guardian every six months as a reminder to schedule a well child visit with the PCP. The parent/guardian of the beneficiary is encouraged to schedule the well child visits recommended during those six months with the beneficiary's PCP. For beneficiaries 2 years of age and older, if a claim for a well child visit has not been processed by Medicaid by the time the child is halfway to their next well child visit due date (according to the AAP periodicity schedule), the parent/guardian will receive a second letter. A list of FFS beneficiaries who did not have a claim for a well child visit processed will be generated and issued to each LHD. LHDs may assist Medicaid in informing parents/guardians of the EPSDT program, scheduling appointments, and arranging medical transportation options.

14.2 MEDICAID HEALTH PLANS (MHP)

Each MHP is able to download an electronic monthly outreach list of enrollees due or overdue for a well child visit. The MHP must either, directly or through the LHD, notify the parent/guardian of the required action or assist in scheduling appointments or arranging medical transportation options. The "Michigan Free Health Check-ups" publication is mailed to the Medicaid beneficiary once each year.

SECTION 15 – MEDICAL TRANSPORTATION

Medical transportation is available free of charge to the beneficiary and parent/guardian for travel to and from well child visits if requested by the family.

- For beneficiaries enrolled in an MHP, the parent/guardian of the beneficiary should make arrangements directly through the MHP.
- The parent/guardian of the beneficiary not enrolled in an MHP should contact their local MDHHS office directly, or with the assistance of the LHD, to make transportation arrangements for the EPSDT well child visit. MDHHS should be contacted as soon as the date and time of the appointment are known.

MDHHS contracts with a transportation brokerage company to arrange and provide Non-Emergency Medical Transportation (NEMT) for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for the service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)

EMERGENCY SERVICES ONLY MEDICAID

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

Aliens who are not otherwise eligible for full Medicaid because of immigration status may be eligible for Emergency Services Only (ESO) Medicaid.

For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part.

SECTION 2 – ELIGIBILITY

Michigan Department of Health and Human Services (MDHHS) determines eligibility for ESO coverage. To qualify for ESO Medicaid, non-citizens must meet all Medicaid eligibility requirements not related to immigration status. The Beneficiary Eligibility Chapter of this manual contains information on how to identify ESO beneficiaries.

Pregnant ESO beneficiaries may also qualify for pregnancy-related services under the MDHHS Maternity Outpatient Medical Services (MOMS) program. Refer to the Maternity Outpatient Medical Services Chapter of this manual for additional information on MOMS covered services.

SECTION 3 – COVERAGE [CHANGE MADE 7/1/2025]

ESO Medicaid coverage is limited to labor and delivery services, and those services necessary to treat emergency conditions. The following services are **not** covered under this benefit:

- preventative services
- follow-up services related to emergency treatment (e.g., removal of cast, follow-up laboratory studies, etc.)
- treatment of chronic conditions (e.g., chemotherapy, etc.)
- sterilizations performed in conjunction with delivery
- organ transplants
- pre-scheduled surgeries

The following table provides additional information regarding specific coverage under the ESO program. Prior authorization and/or copayment requirements may apply to some services listed. Those requirements are described in other chapters of this manual.

Service	Coverage
Ambulance	Limited to emergency transport to a hospital Emergency Department (ED).
Case Management	Not covered
Chiropractor	Not covered
Dental	Not covered
Eyeglasses	Not covered
Family Planning	Not covered
Hearing Aids	Not covered
Home Health	Not covered
Home Help (personal care)	Not covered
Hospice	Not covered

Service	Coverage
Inpatient Hospital	Limited to labor and delivery, and emergency-related services only.
Lab & X-Ray	Limited to services related to labor and delivery, or necessary to diagnose/treat an emergency condition. Follow-up services to emergency treatment are **not** covered.
Medical Supplies/ Durable Medical Equipment (DME)	Medical supplies are limited to those items necessary to treat an emergency condition within an inpatient or outpatient hospital setting. Durable medical equipment is **not** covered.
Mental Health Services	Limited to emergency stabilization of a psychiatric episode within the emergency department of a medical hospital.
Nursing Facility	Not covered
Optometrist	Not covered
Outpatient Hospital/ Emergency Department	Limited to the treatment of emergency conditions. Follow-up care to emergency treatment and chronic care (e.g., chemotherapy, etc.) is **not** covered.
Pharmacy	Limited to those drugs directly related to the emergency condition. Refills are **not** covered. Medicaid copays apply. (Refer to the Pharmacy Chapter of this manual for additional information.)
Physician and Non-Physician Practitioner (NPP) Services	Limited to labor and delivery services, and treatment of an emergency condition. Preventative care, follow-up care to emergency treatment, and chronic care are **not** covered. Medically necessary services provided by physician and non-physician practitioners (NPPs) provided in compliance with state law will be considered for reimbursement.
Podiatrist	Not covered
Prosthetics/ Orthotics	Not covered
Private Duty Nursing	Not covered

Service	Coverage
Substance Abuse	Limited to medically necessary inpatient detoxification services in a life-threatening situation. Inpatient detoxification of a beneficiary who is simply incapacitated is not covered. (Refer to the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of this manual for additional information.)
Therapies	Not covered
Transportation (nonambulance)	Not covered
Ventilator Services	Covered for life-supporting mechanical ventilating services and equipment due to a medical condition where the absence of such treatment could reasonably be expected to cause a medical emergency and place the person's health in serious jeopardy; cause serious impairment to bodily functions; or cause serious dysfunction of any bodily organ or part. Ventilator services shall be prior authorized by the MDHHS Program Review Division (PRD) for up to six months. For additional needed ventilator services, the provider must obtain further prior authorization. Providers must submit documentation supporting the medical necessity of requiring ventilator services to treat a diagnosed medical condition. **(text added per bulletin MMP 25-02)**

FAMILY PLANNING CLINICS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Title X clinic providers. For information related to the services covered for individuals enrolled in the Plan First Family Planning Program benefit plan, refer to the Plan First Family Planning Chapter of this manual.

The Michigan Medicaid Program includes Family Planning services for qualified beneficiaries when the services are determined to be necessary for the health and well-being of the beneficiary. The services provided, as well as the type of provider and setting, must be appropriate to the specific medical needs of the beneficiary. Determination of medical necessity is the responsibility of the attending physician (MD or DO) and must be within the scope of current medical practice and Medicaid limitations. Submission of the claim for payment serves as the provider's certification of the medical necessity for these services. This determination of medical necessity is subject to review, in the context of accepted standards of medical practice.

1.1 EXPLANATION OF SERVICES

A family planning clinic or a primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., certified nurse midwife [CNM], certified nurse practitioner [NP], certified clinical nurse specialist [CNS] or physician assistant [PA]) can provide family planning services. Family planning clinics are limited to providing only family planning services.

Family planning services are defined as any Medicaid covered contraceptive service, including diagnostic evaluation, drugs, and supplies, for voluntarily preventing or delaying pregnancy.

Services must be furnished under the supervision of a physician or dispensed by a pharmacy for beneficiaries of childbearing age, including minors considered to be sexually active. Family planning services enable beneficiaries to voluntarily choose to prevent initial pregnancy or to limit the number of and spacing of their children.

Covered services include an office visit for a complete exam, pharmaceuticals (including some over the counter [OTC] products), supplies and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. Exceptions are condoms and similar supplies which do not require a prescription.

Medicaid does not cover services for treatment of infertility.

1.2 REIMBURSEMENT

If the beneficiary is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for payment for family planning services provided to their enrollees. Family planning clinics are encouraged to establish a contract with the MHP to define services they will provide and reimbursement methodology. MHP enrollees have freedom of choice to obtain family planning services from any family planning clinic provider; therefore, a referral from the MHP is not required.

Michigan Department of Health and Human Services (MDHHS) reimburses for services provided to beneficiaries who are not enrolled in a MHP.

In order to receive reimbursement, family planning clinics must meet established guidelines and be certified by MDHHS. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter. Drugs purchased at 340B prices (actual acquisition costs) will be reimbursed at 340B prices. Medicaid does not reimburse for physician services, lab tests, prescription drugs, or supplies beyond those specified in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule when billed by a family planning clinic. Additional services, when appropriate, are available through the primary care provider and other providers (such as pharmacy, labs, etc.) in accordance with Medicaid policy and procedures. Family planning clinics wishing to provide services in addition to contraceptive management may specifically enroll in the Medicaid program to provide the broader range of services (i.e., Physicians/NPs or Medical Clinics).

Where applicable, special billing instructions for family planning clinics are noted with the service definitions. General billing instructions are located in the Billing & Reimbursement for Professionals Chapter of this manual.

1.3 Diagnosis Codes

The appropriate ICD diagnosis code(s) must be indicated on the claim form when billing for family planning services. Family planning services are limited to the Z30 (ICD-10) code range. Providers must enter the appropriate code on the claim form.

SECTION 2 – OFFICE VISITS

2.1 PREVENTIVE MEDICINE SERVICES - EVALUATION AND MANAGEMENT/OFFICE VISITS

Family Planning Clinic providers are limited to providing preventive services for purposes of delaying or preventing pregnancy (i.e., family planning services). Services provided must be in accordance with the standards of care established for contraceptive management for initial and follow-up services as needed. The appropriate lab services required to manage contraceptive services must be made available, either by the clinic or through a referral process.

Providers must bill using the appropriate Preventive Medicine Evaluation and Management (E/M) codes from the Current Procedural Terminology (CPT) manual and/or the Healthcare Common Procedure Coding System (HCPCS) codes for the services and products listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule. If additional medical problems are identified which need follow-up services, beneficiaries must be referred to their primary care provider.

Counseling services are considered a part of E/M services. As such, no separate reimbursement is available for counseling-only services. The appropriate E/M code that most closely describes the service provided must be billed.

2.2 INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS

Beneficiaries must be given information and education for all methods of contraception available, including reversible methods (e.g., oral, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (e.g., tubal ligation, vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, and difficulty in usage. Basic information concerning sexually transmitted disease (STD) must also be discussed.

Prescriptions for a contraceptive method must reflect the beneficiary's choice, except where such choice is in conflict with sound medical practice.

2.3 PROBLEM VISITS

Beneficiaries should be encouraged to return whenever they have specific problems related to the contraceptive method or wish to have additional guidance or service, including additional supplies. For follow-up care unrelated to contraception, referrals must be made to the primary care provider.

All beneficiaries, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.

SECTION 3 – LABORATORY

Laboratory testing related to contraceptive management or STDs is a covered service. The family planning clinic or a licensed laboratory may provide services. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

Clinics can bill only for services actually performed by the family planning clinic and in the clinic setting. If an outside lab provides the service, that lab must bill Medicaid directly. For example, Pap smear specimens sent for testing to a lab outside the clinic must be billed by the lab performing the lab test.

Clinics seeking reimbursement for lab services are required to obtain Clinical Laboratory Improvement Amendments (CLIA) certification. The type of certification determines the complexity of the lab tests the clinic can perform. If a clinic does not have CLIA certification for specific lab service(s) needed by a beneficiary, the beneficiary should be referred to a provider that has CLIA certification to provide the required laboratory service. The clinic's CLIA certification number must be reported when completing the CHAMPS PE on-line enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information about the CHAMPS PE enrollment application process.) MDHHS may conduct post-payment reviews to verify the certification level and services performed.

Laboratory tests other than those listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule are available to beneficiaries when medically necessary, ordered by a physician or other licensed practitioner working within their scope of practice as determined under State law, and provided by an independent laboratory or outpatient hospital laboratory. For additional information, refer to the Laboratory Chapter of this manual.

SECTION 4 – STERILIZATION

For Medicaid purposes, a sterilization procedure is defined as any medical procedure, treatment, or operation for the purpose of rendering a beneficiary (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). Physicians are responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687) 30 days prior to surgery. A copy of the form can be found in the Forms Appendix of this manual.

Sterilizations are covered only if:

- The beneficiary is at least 21 years of age at time of informed consent;
- The beneficiary is not legally declared to be mentally incompetent;
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility;
- Informed consent is obtained; and
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

4.1 INFORMED CONSENT

Sterilization requires the beneficiary's voluntary informed consent. Persons obtaining the informed consent must adhere to the following requirements:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days, but within 180 days, after signing the MSA-1959/HHS-687 except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains the informed consent must answer any questions the beneficiary may have concerning the procedure.
- Information must be effectively communicated to the deaf, blind, or otherwise physically challenged.
- An interpreter must be provided if the beneficiary to be sterilized does not understand the language on the consent form or used by the person obtaining the informed consent.
- Beneficiaries may have a witness of their choice present when informed consent is obtained.
- A copy of the consent form must be given to the beneficiary.
- Informed consent may not be obtained while the beneficiary to be sterilized is:
  - In labor or childbirth;
  - Seeking to obtain or obtaining an abortion; or
  - Under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

The following information must be presented orally to the beneficiary both at the time the beneficiary signs the consent form and again by the physician performing the sterilization shortly before the procedure, normally during the pre-operative examination.

- The beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- The sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.
- The beneficiary, the person who obtained the consent, and the interpreter or translator (if required) must sign the consent form at least 30 days but no more than 180 days prior to the sterilization. The physician performing the sterilization must sign and date the consent form after the sterilization has been performed.

4.2 Exceptions for Sterilization

All of the above requirements may not be met in some instances, e.g., in cases of premature delivery and emergency abdominal surgery. Exceptions apply when the beneficiary to be sterilized has signed a consent form and, during the required 30-day waiting period, a premature delivery or an emergency abdominal surgery is necessary. To avoid an additional surgery at the conclusion of the required 30-day waiting period, federal regulations permit the sterilization to be performed at the same time as the premature delivery or emergency abdominal surgery if 72 hours have elapsed since the beneficiary signed the consent form. In cases of premature delivery, an additional requirement is that the consent form was signed at least 30 days before the expected delivery date.

4.3 Reimbursement Policy for Sterilization

Pre- and post-operative examinations for the sterilization procedure are included in the reimbursement for the surgical procedure. No additional reimbursement is allowed for the pre-operative examination or the sterilization explanation.

Reimbursement for a vasectomy includes pre- and post-operative visits for counseling, clamp removal, the post-operative semen analysis, etc. No additional charges are allowed for these services and Medicaid does not make separate payment.

Reimbursement for female sterilization and other related medical procedures are available to Medicaid enrolled physicians performing the sterilization. Physicians must bill using their provider NPI number in these cases.

4.4 Special Billing Instructions

All items of the MSA-1959/HHS-687 must be completed except in the following circumstances:

- The ethnic information is optional.
- The interpreter statements must be completed only when applicable.

All invoices submitted to MDHHS by the clinic for the sterilization must include a copy of the fully completed MSA-1959/HHS-687. (Refer to the Forms Appendix for additional information.) This requirement applies to all practitioners, technical surgical assistants, anesthesiologists, etc., as well as the hospital and clinics. All sterilization claims suspend and documentation is reviewed by MDHHS. Invoices submitted without the appropriate documentation are rejected. If any field on the form is improperly completed, the claim will be rejected.

When billing for charges related to a sterilization procedure, a copy of the completed MSA-1959/HHS-687 must be included. This form may be submitted by fax or accompany the claim. (Refer to the Directory Appendix for contact information.)

4.5 Consent Form for Sterilization

MDHHS allows submission of MSA-1959/HHS-687 forms via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any sterilization procedure. Submitting the form via fax eliminates attachments to claims and confirms that the form is acceptable, thus reducing costly claim rejections.

The provider who obtains the consent and completes the MSA-1959/HHS-687 may fax or mail the completed consent form, along with a cover sheet, to the Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider via the same method it was submitted. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted to MDHHS without paper attachments.

4.6 Procedure for Submitting the Consent for Sterilization Form

Providers must complete the following steps when submitting a MSA-1959/HHS-687:

- Complete a cover sheet according to Document Management Portal instructions.
- Fax the cover sheet and completed consent form to Medicaid Payments Division, Sterilization Consent Form Approval. Do not fax invoices.
- Wait for a response. When notified that the consent form has been accepted and is on file, inform other providers via a copy of the response.
- Providers may then submit claims (either electronic or hard copy) to MDHHS. The Remarks section or Comment Record must include the statement "Consent on File."
- When sterilization claims are received with this information in the Remarks section, the claim is forced for payment if the submitted invoice matches the consent form on file.

- If there is no response from MDHHS within five working days, review the request submitted to ensure that MDHHS received the fax (i.e., confirm that the fax is working, make sure the cover sheet included the necessary provider contact information, etc.). Resend the information if necessary.

Providers have the option to attach a copy of the MSA-1959/HHS-687 to the claim without going through the pre-approval process outlined above.

SECTION 5 – PHARMACEUTICALS

Clinics may dispense and receive reimbursement for contraceptives and limited pharmaceutical supplies. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

Dispensed oral contraceptives, vaginal rings, and contraceptive hormonal patches may not exceed a 12-month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Depo Provera.

If the only service provided is supplies, no visit code may be billed. A billing unit must equal a billing quantity of one on the claim.

Medicaid covers a broader range of pharmaceuticals than those listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule. These products must be prescribed by a physician and dispensed by a Medicaid-enrolled pharmacy. The Pharmacy Chapter of this manual or the local pharmacy may be referenced/contacted for details.

5.1 SPECIAL BILLING INSTRUCTIONS

If a pharmaceutical, contraceptive supply, or medical device is purchased at the 340B price, the actual acquisition cost must be billed to Medicaid. In addition, drugs purchased through the 340B program must be indicated as such on the claim. Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20. (Refer to the Billing & Reimbursement for Professionals Chapter for additional information.)

SECTION 6 – OTHER SERVICES

6.1 REFERRALS

Each clinic is responsible for making appropriate referrals in the following circumstances:

- Medical problems identified by the history or physical examination
- All positive Gonorrhea and other STD cultures and/or serology
- Vaginal infections
- Beneficiaries with abnormal cervical cytology
- Beneficiaries with positive urine cultures
- Prenatal services
- Beneficiaries suffering from anemia
- Female sterilizations

6.2 INPATIENT SERVICES

Each clinic must make arrangements for inpatient care for fee-for-service (FFS) beneficiaries requiring inpatient care as a result of complications arising from contraceptive services provided by that clinic. Arrangements for MHP enrollees must be made through the MHP.

6.3 EMERGENCY SERVICES

Each clinic must have a mechanism in place for handling emergency services related to contraceptive services after regular clinic hours.

FEDERALLY QUALIFIED HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Federally Qualified Health Centers (FQHCs), designated FQHC look-alikes, and Tribal Health Centers (THCs) electing to be reimbursed as an FQHC. Subsequent references to FQHCs in this chapter are applicable to all three entities. This chapter provides policy and reimbursement information specific to FQHCs and is to be used in combination with other chapters in this manual.

Section 330 of the Public Health Service Act establishes guidelines for health centers applying for grant funding under the Health Centers Consolidation Act of 1996 (Public Law 104-299). This act combined four federal health center grant programs under one authority (community, migrant, homeless and public housing). Health centers applying for, and meeting the criteria for, grant funding under Section 330 are eligible to be recognized as FQHCs by Centers for Medicare & Medicaid Services (CMS) for reimbursement purposes. Once FQHC status is designated by CMS and notification of that status is provided to the Michigan Department of Health and Human Services (MDHHS), an FQHC is eligible to enroll with Medicaid as an FQHC provider in the State of Michigan.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 makes provision for the reimbursement of FQHCs under a prospective payment system (PPS). Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. This PPS applies to the ambulatory/outpatient medical services that FQHCs are required, under federal regulation, to provide to Medicaid beneficiaries.

States may elect to reimburse FQHCs under the PPS methodology outlined in the Act or they may choose to implement an alternative payment methodology, referred to as the Memorandum of Understanding (MOU). The MOU must be agreed to by both the state and the FQHC. If an alternative payment methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the PPS. Refer to the Alternative Payment Methodology subsection of this chapter for additional information.

1.1 ENROLLMENT

Each FQHC that is certified by CMS to provide services as a Medicare-enrolled FQHC is eligible to apply to MDHHS to be a Medicaid provider. To apply, the FQHC must complete the on-line CHAMPS Provider Enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for enrollment information.)

MDHHS requires all FQHCs to have a Type 2 (Organization) National Provider Identification (NPI) number in order to receive the enhanced FQHC reimbursement. For FQHCs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the FQHC fails to obtain and/or use the correct NPI number, the FQHC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

FQHC services that are furnished under contract with physicians, clinical social workers, clinical psychologists, physician assistants, certified family and pediatric NPs, visiting nurses, and other approved

professionals are billed as FQHC services. However, preventive primary services must be provided by an employee of the FQHC or by a physician under contract with the FQHC. Preventive primary services do not qualify as FQHC services if non-employee providers (except physicians) contracting with the FQHC provide the services.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

1.1.A. Non-Physician Behavioral Health Services

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral levels), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers to provide behavioral health services. The NPI of the psychologist, social worker, professional counselor, or marriage and family therapist is reimbursed under the FQHC PPS or MOU. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.

1.2 Site Specific Certification

FQHCs are required to report CMS and Health Resources and Services Administration (HRSA) site-specific certification numbers for each site operated by the FQHC as part of the CHAMPS PE online enrollment process. Satellite(s) and/or mobile center(s) locations not approved by HRSA as a Section 330 eligible site will not be eligible for PPS or MOU reimbursement.

FQHCs are required to notify the MDHHS Hospital and Clinic Reimbursement Division (HCRD) in writing within seven (7) business days of any of the following changes:

- HRSA notification of lost FQHC status; or
- Opening(s) and/or closing(s) of any HRSA approved satellite(s) and/or mobile center(s) sites.

1.3 Allowable Places of Service

Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellite(s) and/or mobile center(s) are allowable for reimbursement under the PPS or the MOU. Off-site services provided by employed practitioners of the FQHC to beneficiaries temporarily homebound or in any

assisted living or skilled nursing facility because of a medical condition that prevents the beneficiary from traveling to the FQHC are also allowable for reimbursement under the PPS or the MOU.

If a practitioner employed by an FQHC provides services at an inpatient hospital, the service must be billed under the individual practitioner's NPI and will be reimbursed the appropriate fee screen rate. Services performed in an inpatient hospital setting are not included under the PPS or MOU. The costs that are associated with these services must be excluded from the FQHC's Medicaid Reconciliation Report.

1.4 Nonenrolled Provider Services

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the FQHC PPS or MOU. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject. The clinical psychologist and clinical social worker services must be billed with the appropriate procedure codes that reflect the services provided.

Services provided by clinical psychologists and clinical social workers are included in the outpatient visits for MHP members. FQHCs must participate as part of a MHP provider panel in order to bill for services provided to members, and all services must be prior authorized by the respective MHP.

SECTION 2 – BENEFITS

FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(3)(A)-(B) of the Social Security Act.

2.1 PRIMARY CARE SERVICES

Primary care services are defined as:

- Those required under Section 330 of the Public Health Service Act.
- Medicaid-covered services provided in a place of service that is the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility (NF), or Skilled Nursing Facility (SNF) by a provider type physician, medical clinic, podiatrist, dentist, CNP or CNM.
- Visits by a clinical psychologist or clinical social worker at the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility.
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Infant Health Program (MIHP) services.

2.2 TRANSPORTATION/OUTREACH

The cost of outreach and non-emergency transportation is part of an FQHC's encounter rate. These services are not cost settled.

The FQHC provides non-emergency transportation to and from the FQHC for Medicaid covered services provided to Medicaid Fee-for-Service beneficiaries. For Medicaid managed care enrollees, the FQHC may provide transportation in certain circumstances. Refer to the Managed Care Programs section of the Non-Emergency Medical Transportation chapter for additional information.

2.3 TELEMEDICINE

An FQHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Professionals Chapter for specific billing instructions. Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

2.4 ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP) VACCINES [CHANGE MADE 4/1/2025]

FQHCs providing Advisory Committee on Immunization Practices (ACIP) recommended vaccines for beneficiaries 19 years of age and older in FQHC settings will be reimbursed outside of the Prospective Payment System (PPS) methodology. Reimbursement for ACIP recommended vaccines will be made up to the applicable Medicaid fee screen rates. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.) FQHCs obtaining vaccines at a lower than normal cost through the 340B Program must report the 340B acquisition price on the claim. **(text added per bulletin MMP 24-50)**

2.5 Children's Health Insurance Program Services

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through FQHCs when covered by the Children's Health Insurance Program (CHIP). Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act.

For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual reconciliation of these encounters provided by FQHCs. (Refer to the Medicaid Health Plans subsection of this chapter for additional information.)

For Healthy Kids–Expansion, MIChild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by FQHCs. The FQHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.

SECTION 3 – ENCOUNTERS

3.1 DEFINITION

An allowable FQHC encounter means a face-to-face medical visit or an interaction using a qualifying telemedicine modality (audio/visual or audio-only) between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. Encounters may be classified as medical, dental, or behavioral health.

An encounter occurs between a medical provider and a patient when medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of an illness or injury. Included in this category are physician visits and mid-level practitioner visits. Family planning medical visits are a subset of medical visits.

An encounter occurs between a dentist, dental hygienist, or dental therapist and a patient when services are for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. A dental hygienist and dental therapist are credited with an encounter only when the professional provides a service independently, not jointly with a dentist. However, two encounters may not be billed for the dental clinic in one day.

An encounter occurs between a speech or physical therapist, audiologist, occupational therapist, clinical psychologist, or clinical social worker and a patient when allied health or mental health services are provided. Allied health services are those provided by specially trained health workers, other than medical and dental personnel. Mental health services are those of a psychological or crisis intervention nature or related to alcohol or drug abuse treatment. For the purpose of these reports, visits with a psychiatrist are included under medical visits.

The following examples help to define an encounter:

- To meet the encounter criteria for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, or optician services, in and of themselves, do not constitute encounters. However, these procedures may accompany services performed by medical, dental, or other health providers that do constitute encounters.
- Encounters must be documented in the medical record. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in each person's health record. This also applies to family therapy or counseling sessions in which several members of the family receive services relating to mutual family problems and the services are noted in each family member's health record.
- The same timely filing billing limitations identified in the General Information for Providers Chapter of this manual apply to claims submitted for FQHC encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a larger scale effort, such as a mass immunization program, screening program, or community-wide service program.
- When the following services are provided as stand-alone services: taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling/dispensing prescriptions. Refilling prescriptions, filling out insurance forms, etc. are not visits. Allergy injections are not visits.

3.2 Medicaid Health Plans

Medicaid-covered services provided by an FQHC to Medicaid-eligible beneficiaries enrolled with an MHP are subject to the PPS when the following conditions are met:

- The FQHC and the MHP must be signatories to a contract that addresses the FQHC providing Medicaid covered services to an MHP enrollee.
- The contract must provide for the MHP to reimburse the FQHC at a fair market rate for similarly situated beneficiaries served by a non-PPS provider. The contractor must implement a payment method equal to, or above that of, other affiliated inter-plan and intra-plan subcontracting arrangements when entering into a subcontract with an FQHC.
- The FQHC must submit documentation of the encounters and payments when requesting MDHHS pay the PPS rate for health plan enrollees.

MHP beneficiaries are identified in the eligibility response with the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC. Providers must verify eligibility before providing services. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

3.3 Healthy Kids Dental

Dental services provided to Medicaid beneficiaries enrolled in the ***Healthy Kids Dental*** program are subject to the PPS or MOU rate.

3.4 Substance Use Disorder Services

Selected services provided by an FQHC will be included in the FQHC annual reconciliation when a contract exists between the FQHC and the behavioral health contracting entity. FQHCs that have a contract in place with a behavioral health agency must follow the service and billing arrangements set forth by the contract. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)

3.5 Allowable Encounters Per Day

An FQHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of three encounters are allowed per beneficiary per day (one medical, one dental, and one behavioral health). In

cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters.

- Example 1: A beneficiary sees a dentist for an exam and three restorations and sees the dental hygienist for a prophylaxis on the same day. These visits count as one encounter (dental).
- Example 2: A beneficiary sees a physician at the FQHC, and then later sees a dentist and a social worker on the same day. These visits may be classified as three encounters (one medical, one dental, and one behavioral health).
- Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).

3.6 Services and Supplies Incidental to an FQHC Encounter

Services and supplies incidental to a FQHC encounter are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral, part of professional services furnished by a physician, CNP, CNM, or physician's assistant.
- Furnished under the direct personal supervision of a physician, CNP, CNM, or physician's assistant.
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a CNP, CNM, or physician's assistant only if such a person is permitted to supervise such services under the written policies governing the FQHC.

SECTION 4 – BILLING

FQHC providers are expected to practice in accordance with the accepted standards of care and professional guidelines applicable to medical, dental, and behavioral health services, and comply with all applicable policies published in the Michigan Medicaid Provider Manual. FQHC services must be billed according to instructions published in the Billing & Reimbursement for Institutional Providers Chapter of this manual. FQHCs must refer to this chapter for information needed to submit claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the FQHC of its action. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the FQHC to properly bill all Medicaid FFS claims. Since the annual reconciliation and final reimbursement is based on approved Medicaid claims, incorrect or improper billing may adversely affect reimbursement.

The Type 2 (Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number of the practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field:

- Physicians (includes dentists, podiatrists, optometrists, and chiropractors)
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Licensed Psychologists (Doctoral Level)
- Social Workers (Master's Level)
- Professional Counselors (Master's or Doctoral levels)
- Marriage and Family Therapists
- Limited Licensed Psychologists (Master's or Doctoral Level)

Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Type 2 (Organization) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

The FQHC's MDHHS-approved claims must be available for review by authorized personnel or agents of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, and U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act. Inappropriate payments identified in post-payment review are subject to recoupment. The FQHC has the full responsibility to maintain proper and complete documentation to verify the services provided.

4.1 Place of Service

Place of service codes are not applicable to institutional billing. However, if the FQHC performs a service that must be billed on the professional claim form within the FQHC, the appropriate place of service code is 50. For services not provided in the FQHC, bill the appropriate place of service (POS) code listed in the Billing & Reimbursement for Professionals Chapter of this manual.

FQHCs providing Medicaid-covered services in locations other than the FQHC office, home, nursing facility or domiciliary facility are reimbursed at Medicaid fee screens.

4.2 Billing for Maternity Care

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (FQHC and hospital). In order for the FQHC to be reimbursed for prenatal visits under the PPS methodology, the FQHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology.

If the FQHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

4.2.A. Billing Requirements for Group Prenatal Care Services

Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology at the Medicaid fee screen reimbursement rates for these services. FQHCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) codes as identified in the Billing & Reimbursement for Professionals chapter of this manual.

4.3 Clinical Trials

The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information.

All FQHC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. (Refer to the Clinical Trials subsection of the Billing & Reimbursement for Institutional Providers chapter for additional information.) In addition, FQHC claims must include:

- A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)

- Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim.
- Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1.
  - HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study
  - HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.

4.3.A. Reporting Non-Covered Services

Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.

4.4 Other Insurance

Billing instructions related to coordination of benefits are contained in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the FQHC must still bill the procedure code to receive credit for the encounter.

4.5 Medicare and Medicaid Crossover Claims

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate FFS procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

4.6 Copayments

Medicaid copayments for chiropractic, dental, physician, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation.

4.7 Dental Claims

FQHCs providing dental services must refer to the Dental and to the Billing & Reimbursement for Dental Providers chapters of this manual for information regarding program coverages, prior authorization requirements, claim completion, and billing instructions.

SECTION 5 – MEDICAID RECONCILIATION REPORT

5.1 RECONCILIATION OF FEE-FOR-SERVICE

Each FQHC is required to submit an annual Medicaid Reconciliation Report. MDHHS will include, as part of the annual Medicaid Reconciliation Report, fee-for-service (FFS) primary care services claims that are approved through the claims system. In order for this to occur, all FFS primary care services must be submitted and processed through CHAMPS. (Refer to the Primary Care Services subsection in this chapter.) Every individual provider or electronic biller (the billing agent) receives a remittance advice (RA) for services that are billed. The RA informs the provider of the action taken on claims. It is the responsibility of FQHC providers to monitor claim activity and take appropriate steps to resolve suspended and rejected claims prior to the final reconciliation. (Refer to the Billing & Reimbursement Chapters of this manual for additional billing information.)

For non-primary care services, the FQHC will receive the Medicaid FFS amounts or the amount agreed to with the MHP as payment in full. The FQHC may enter into a risk contract with the MHP for services not included in the primary care definition. Non-primary care services and risk contracts will not be reconciled and are not included in the Medicaid Reconciliation Report.

5.2 DOCUMENTING ENCOUNTERS

Encounter data for FQHCs services provided to beneficiaries through Medicaid Health Plans, ***Healthy Kids Dental***, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS).

No individual payment information is needed if health plan payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided.

Upon review and audit, MDHHS will reimburse the difference between the FQHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the regional PIHP.

5.3 RECONCILIATION OF QUARTERLY ADVANCES

Quarterly advances are included as Medicaid revenue on the Medicaid Reconciliation Report and are reconciled with the FQHC PPS. The quarterly payment will be made on the RA at the beginning of each quarter.

Quarterly advances are an estimate of the difference between the payments that an MHP, PIHP, or Dental Health Plan (DHP) make to the FQHC, and the payments the FQHC would have received under the PPS. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment through the MDHHS HCRD.

5.4 Reconciliation of Transportation/Outreach

Medicaid outreach and non-emergency transportation are combined into the all-inclusive encounter rate. Transportation requirements are defined in the Benefits Section of this chapter.

5.5 Prospective Payment Rate

An FQHC is reconciled to the prospective payment rate (PPR) determined under the PPS or the MOU. In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000. The PPR amount is an all-inclusive rate that covers all defined primary care services. (Refer to the Medicaid Reconciliation Report subsection of this section for a definition of reasonable costs.) The per visit amount is adjusted annually using the Medicare Economic Index (MEI) based on changes in the MEI for the prior calendar year.

5.6 Prospective Payment Rate for New FQHC Sites

An entity that initially qualifies as an FQHC after fiscal year 2000 will be paid as follows:

- Upon enrollment, an interim prospective payment rate (PPR) will be established for new FQHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The FQHC will be cost settled at the end of its first fiscal year of operation.
- After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria:
  - The first year will be inflated to the second fiscal year end using the appropriate MEI factors.
  - The PPR shall not exceed the Medicare limit (rural or urban depending upon classification) plus the Medicaid add-on amounts adjusted for MEI.

Newly established FQHCs shall be paid using the PPS methodology or may agree to payment in accordance with the MOU. A newly established FQHC is eligible for quarterly payments. The amount of the quarterly payment will be estimated until the first reconciliation period.

5.7 Adjustments to the Prospective Payment Rate

The prospective payment rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by an FQHC. All scope of service changes are made on a prospective basis. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC. (Refer to the Scope of Service subsection of this section for additional information.)

5.8 Alternative Payment Methodology

In accordance with State Plan authority, MDHHS may enter into an alternative payment methodology with an FQHC, referred to as a Memorandum of Understanding (MOU). Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid beneficiaries is subject to the terms of the signed

MOU. For an FQHC paid under the MOU, the PPS base methodology described within this chapter will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Social Security Act.

The MOU is effective when both MDHHS and an FQHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The MOU does not supersede any corresponding policy in the Michigan Medicaid Provider Manual, but documents the clinic's acceptance of the terms outlined in the Michigan Medicaid State Plan. If an FQHC does not sign the MOU, reimbursement and corresponding policy defaults to that which is described under the PPS methodology and outlined in this manual.

5.9 Scope of Service

5.9.A. Increase/Decrease in Scope of Service

The prospective payment rate may be adjusted for an increase or decrease in scope of service. Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default).

- An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved FQHC benefits that no current professional staff is licensed to perform.
- A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service does not result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic.
- An increase, decrease or change in office hours.
- An increase, decrease or change in office space or location.
- The addition of a new site that provides the same set of services.
- An increase, decrease or change in equipment or supplies.
- An increase, decrease or change in the number or type of patients served.

5.9.B. Notice of Intent to Change Scope of Service

If an FQHC intends to change its scope of service, the MDHHS HCRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. It is the responsibility of the FQHC to notify MDHHS for an increase or decrease in scope of service. Notification should include the following documentation:

- A complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of visits.
- Estimates of the cost change on the current Medicaid per visit rate.
- The proposed customary charges for this service by the clinic.
- The customary charges for this service by other providers in the area served by this clinic.
- The amount to be paid by a MHP for this service for various programs (Medicare/Medicaid).
- Medicare fee screen for this service for non-PPS providers.
- The current Medicare visit rate.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.) and type (MHP, fee screen, contracted amount).
- Estimated increase in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from state licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, visits or approvals/denials of the change.
- Other information as requested by the MDHHS HCRD.

After a review of the information submitted, the MDHHS HCRD determines if a per visit rate change will be made and notifies the FQHC, specifying the effective date of any change. All scope of service changes are made on a prospective basis.

5.10 Medicaid Reconciliation Report

Each FQHC must complete a Medicaid Reconciliation Report for its fiscal year. The MDHHS HCRD must receive the report by the due date for the Medicare Cost Report in order for the FQHC to receive PPS reimbursement.

The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its Medicaid Reconciliation Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.

The Medicaid Reconciliation Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.

5.10.A. Reasonable Costs

Reasonable costs are defined as the per visit amount approved and paid by Medicare as of October 1, 2001, and then adjusted to reflect the cost of providing services to Medicaid beneficiaries who are not covered by Medicare.

5.10.B. Maintenance of Medical and Financial Records

The FQHC must maintain, for a period of not less than seven years, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or the expenses will be disallowed.

The MDHHS HCRD will maintain each required FQHC Medicaid Reconciliation Report submitted by the provider for seven years following the date of submission of the report. In the event that there are unresolved issues at the end of this seven-year period, the report will be maintained until such issues are resolved.

The financial and clinical records of the FQHC must be available for review by authorized personnel or agents of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, and the U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act.

SECTION 6 – AUDITS, RECONCILIATIONS AND APPEALS

6.1 QUARTERLY ADVANCES AND RISK CONTRACTS

The FQHC's quarterly advances will be reconciled annually on the reconciliation report. Risk contracts will not be reconciled.

6.2 RECONCILIATION AND SETTLEMENTS

6.2.A. INITIAL SETTLEMENTS OF FQHCS

An initial settlement is calculated annually. Calculations are determined from the filed FQHC Medicaid Reconciliation Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable reconciliation report. MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

6.2.B. FINAL SETTLEMENTS OF FQHCS

Final settlements for FQHCs are generally completed within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Reconciliation Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

The Medicare intermediary field and/or desk audit may cause MDHHS to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDHHS may process a revised Medicaid final settlement for the period covered by the reconciliation report.

6.2.C. UNDERPAYMENTS TO FQHCS

MDHHS staff process the full amount of the final settlement through a gross adjustment.

6.2.D. OVERPAYMENTS TO FQHCS

Once a determination of overpayment has been made, the amount determined is a debt owed to the State of Michigan and shall be recovered by MDHHS. The recovery will start approximately 30 days after notification to the FQHC. A credit gross adjustment will stop all payments to the FQHC physician(s) until the amount is recovered. This amount will be reflected on the Remittance Advice (RA).

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid settlements.

6.3 Response to the Audit Adjustment Report

MDHHS staff prepares the Audit Adjustment Report, which contains a descriptive list of all Medicaid data adjustments made to the Medicaid Reconciliation Report by MDHHS audit staff. The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date.

The FQHC may take the following actions:

FQHC Accepts the Report	If the FQHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the FQHC must sign the report and mail it to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement will be mailed to the FQHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.
FQHC Does Not Respond	If the FQHC does not respond within this time period, MDHHS shall issue a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.
FQHC Rejects the Report	If the FQHC rejects any or all of the findings contained in the Audit Adjustment Report, the FQHC may request a Post-Audit Conference within 30 calendar days from the date of receipt of the Audit Adjustment Report.

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

6.4 Medicaid Appeals

Medicaid providers have the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which the MDHHS had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the General Information for Providers Chapter of this manual and in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended, and filed with the Secretary of State on May 19, 2016. Any questions regarding this appeal process should be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

SECTION 7 – MI CARE TEAM (PRIMARY CARE HEALTH HOME BENEFIT)

7.1 GENERAL INFORMATION

Effective July 1, 2016, MDHHS implemented a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting. The MI Care Team has an operations guide for providers called the MI Care Team Handbook. In addition, the MI Care Team has a website with provider resources. (Refer to the Directory Appendix for website information.)

Note: The benefit will continue as program evaluations are completed.

7.2. BENEFICIARY ELIGIBILITY

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of depression and/or anxiety in addition to a diagnosis of one of the following:

- Asthma
- Diabetes
- Hypertension
- Heart Disease
- Chronic Obstructive Pulmonary Disease

7.3 BENEFICIARY ENROLLMENT

7.3.A. ENROLLMENT PROCESSES

The MI Care Team uses a two-pronged enrollment approach where both MDHHS and Health Home providers participate. The process is as follows:

- MDHHS will identify potential eligible beneficiaries using claims data and send each beneficiary a letter notifying them of their eligibility. MDHHS will also provide a list of potential eligible beneficiaries to designated MI Care Team providers with whom they have an established relationship. The list of eligible beneficiaries will be updated and maintained on a monthly basis. Enrollment is contingent on beneficiary consent (refer to the Beneficiary Consent subsection), and beneficiary assignment will occur only after a beneficiary visits a MI Care Team provider, fills out the enrollment and consent forms, and establishes a Health Action Plan (an individualized care plan). These steps must be documented.
- MI Care Team providers are permitted to recommend potential eligible beneficiaries for enrollment to MDHHS. MI Care Team providers must provide documentation that indicates that a prospective MI Care Team beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an

individualized care plan. MDHHS shall authorize all beneficiary eligibility and process approved enrollments.

7.3.B. Beneficiary Consent

Beneficiaries must provide a signed MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030) and a signed Consent to Share Behavioral Health Information form (MDHHS-5515) to enroll in and receive the MI Care Team benefit. Signed enrollment and consent forms must be collected and retained in the beneficiary's health record. Providers are responsible for verifying receipt of signed enrollment and consent forms and providing proper documentation to MDHHS. All documents must be maintained in compliance with MDHHS record-keeping requirements.

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

7.3.C. MI Care Team Benefit Plan Assignment

Once the steps outlined above are completed, the beneficiary will be assigned a benefit plan of HHMICARE associated to their Medicaid member ID in CHAMPS. It is incumbent upon MI Care Team providers to verify a beneficiary's HHMICARE assignment prior to rendering services. Beneficiaries without the benefit plan assignment of HHMICARE are not eligible for MI Care Team payment.

7.3.D. Beneficiary Disenrollment

Beneficiaries may disenroll from the MI Care Team benefit at any time. Beneficiaries who decline enrollment initially may elect to enroll at a later date contingent on meeting

eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other medically necessary services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into the following two groups which have unique disenrollment processes:

- Beneficiaries who have moved out of an eligible geographic area, died, or are otherwise no longer eligible for Medicaid program benefits will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.
- Beneficiaries who are unresponsive for reasons other than moving or death. Providers must make three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. Providers will not receive payment for unsuccessful contacts. Providers must provide documentation for each unsuccessful contact attempt. After the final unsuccessful attempt, providers will recommend disenrollment to MDHHS with proper documentation.

Providers should process disenrollments by completing the disenrollment section of the MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030). Moreover, providers must document disenrollments in the Waiver Support Application. MDHHS requires that providers try to re-establish contact with disenrolled beneficiaries at least bi-annually, as applicable.

7.3.E. Beneficiary Changing MI Care Team Providers

To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen MI Care Team provider. However, beneficiaries may change MI Care Team providers, and should notify their current MI Care Team provider immediately if they intend to do so. The current and future MI Care Team providers must discuss the timing of the transfer and communicate transition options to the beneficiary. Additionally, the beneficiary must complete new enrollment and consent forms (MI Care Team Beneficiary Enrollment/Disenrollment form [MSA-1030] and a signed Consent to Share Behavioral Health Information form [MDHHS-5515]). The MI Care Team provider change should occur on the first day of the next month with respect to the new provider's appointment availability. Only one MI Care Team provider may be paid per beneficiary per month. The new MI Care Team provider will also not be eligible for the initial "Access and Health Action Plan" payment if that one-time payment was already made to another MI Care Team provider. (Refer to the MI Care Team Payment subsection of this policy for additional information.)

7.4 Covered Services

MI Care Team services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. These services include the following:

- **Comprehensive Care Management**, including but not limited to:
  - Assessment of each beneficiary, including behavioral and physical health care needs;
  - Assessment of beneficiary readiness to change;
  - Development of a Health Action Plan;
  - Documentation of assessment and Health Action Plan in the Electronic Health Record; and
  - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.
- **Care Coordination and Health Promotion**, including but not limited to:
  - Organization of all aspects of a beneficiary's care;
  - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
  - Information sharing between providers, patient, authorized representative(s), and family;
  - Resource management and advocacy;
  - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
  - Appointment-making assistance, including coordinating transportation;
  - Development and implementation of a Health Action Plan;
  - Medication adherence and monitoring;
  - Referral tracking;
  - Use of facility liaisons;
  - Use of patient care team huddles;
  - Use of case conferences;
  - Tracking of test results;
  - Requiring discharge summaries;
  - Providing patient and family activation and education;
  - Providing patient-centered training (i.e., diabetes education, nutrition education, etc.); and

- Connection of beneficiary to resources (i.e., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

- **Comprehensive Transitional Care**, including but not limited to:
  - Connecting the patient to health services;
  - Coordinating and tracking the patient's use of health services;
  - Providing and receiving notification of admissions and discharges;
  - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
  - Post-discharge outreach to assure appropriate follow-up services;
  - Medication reconciliation;
  - Pharmacy coordination;
  - Proactive care (versus reactive care);
  - Specialized transitions when necessary (i.e., age, corrections); and
  - Home visits.
- **Patient and Family Support**, including but not limited to:
  - Reducing barriers to the beneficiary's care coordination;
  - Increasing patient and family skills and engagement;
  - Use of community supports (i.e., community health workers, peer supports, support groups, self-care programs, etc.);
  - Facilitating improved adherence to treatment;
  - Advocating for individual and family needs;
  - Assessing and increasing individual and family health literacy;
  - Use of advance directives;
  - Providing assistance with maximizing beneficiary's level of functioning; and
  - Providing assistance with development of social networks.
- **Referral to Community and Social Support Services**, including but not limited to:
  - Providing beneficiaries with referrals to support services;
  - Collaborating/coordinating with community-based organizations and key community stakeholders;
  - Emphasizing resources closest to the beneficiary's home;
  - Emphasizing resources which present the fewest barriers;
  - Identifying community-based resources;
  - Providing resource materials pertinent to patient needs;
  - Assisting in attaining other resources, including benefit acquisition;

- Providing referral to housing resources; and
- Providing referral tracking and follow up.

- **Use of Health Information Technology to link services**, including but not limited to:
  - Use of an Electronic Health Record with meaningful use attainment;
  - Use of CareConnect360 for care coordination, transition and planning; and
  - Use of telemedicine as needed.

7.5 Provider Eligibility Requirements

Eligible providers are selected by MDHHS through its Invitation-to-Bid (ITB) process. Applicants are selected on the basis of meeting the requirements outlined in the ITB. Selected MI Care Team providers will assure that all requirements are met and maintained. Failure to meet and maintain these requirements can result in loss of MI Care Team eligibility.

7.5.A. Geographic Area

Eligible providers must implement the MI Care Team in geographic areas determined by the ITB process.

7.5.B. Provider Types

Eligible provider types for the MI Care Team are Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, and Tribal Health Centers (THCs).

7.5.C. Provider Requirements

Providers must meet the requirements indicated in the ITB, the MOU, and the MI Care Team Handbook. (Refer to the Directory Appendix for website information.)

7.5.D. Provider Infrastructure Requirements

MI Care Team providers will assure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The on-site care team must consist of, at a minimum, the following:

- Primary Care Provider
  - Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable)
- Behavioral Health Consultant
  - Must be a licensed master's level social worker in Michigan
- Nurse Care Manager
  - Must be a licensed registered nurse in Michigan

- Community Health Worker (CHW)
  - Must be at least 18 years of age
  - Must possess a high school diploma or equivalent
  - Must be supervised by licensed professional members of the care team
  - MDHHS strongly encourages the completion of a CHW Certificate Program
- Health Home Coordinator
  - Must be an administrative staff person employed by the eligible provider
- Access to a Psychiatrist/Psychologist for consultation purposes (can be off-site)
  - Must be a doctoral level licensed psychiatrist or psychologist in Michigan

In addition to the above required provider infrastructure, eligible providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

7.6 Provider Enrollment and MI Care Team Designation

All providers selected through the ITB process and meeting the requirements in the Provider Eligibility Requirements subsection of this policy may enroll as a designated MI Care Team provider contingent upon adherence to this policy and the MI Care Team MOU. MDHHS will provide, in writing, the MOU and any other contingencies needed to obtain or preserve MI Care Team designation. Providers must sign and attest to adhere to this policy and the MOU and return to MDHHS. Only after MDHHS receives this signed attestation will a provider become a designated MI Care Team provider.

7.6.A. Training and Technical Assistance

MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued MI Care Team designation. A readiness assessment will be completed for each designated MI Care Team site which will provide a basis for training and technical assistance needs.

7.6.B. Use of Applicable Health Information Technology (HIT)

MDHHS requires MI Care Team providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources will be provided by MDHHS.

7.7 Provider Disenrollment

To maximize continuity of care and the patient-provider relationship, MDHHS expects MI Care Team providers to establish a lasting relationship with enrolled beneficiaries. However, designated MI Care Team providers wishing to discontinue MI Care Team services must notify MDHHS at least six months in advance of ceasing MI Care Team operations. MI Care Team services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

7.8 MI Care Team Payment

Payment for MI Care Team services is contingent on designated MI Care Team providers meeting the requirements laid out in this policy and in the MOU, and as determined by MDHHS. Failure to meet these requirements may result in loss of MI Care Team provider designation.

7.8.A. General Provisions for MI Care Team Payment

To provide MI Care Team services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS), including enrollment as a billing agent or utilization of an existing billing agent to bill for and receive the MI Care Team payments. Designated MI Care Team providers have their own CHAMPS identifier which must be used to submit encounters for MI Care Team Services. This identifier is only used for documenting MI Care Team services. The Type 2 (Organization) National Provider Identifier (NPI) number must be used as the billing provider on all MI Care Team service encounters submitted. The billing provider loop or field is mandatory to complete. The Provider (Type 1 - Individual) NPI number of the provider who performed the service encounter, or the supervising physician, should be entered as the rendering provider. If the provider who performed the service is not enrolled in CHAMPS (e.g., CHW), then a supervising primary care provider must be entered as the rendering provider (i.e., primary care physician, nurse practitioner, physician's assistant). Designated MI Care Team providers should use their standard NPI for payment of regular (non-MI Care Team) clinical services.

Designated MI Care Team providers are paid one of two monthly case rates, which are as follows:

- **Health Action Plan Rate**

  The MI Care Team uses a once-in-a-lifetime-per-beneficiary Health Action Plan rate to be paid only for the first month that a beneficiary participates in the MI Care Team program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services including, but not limited to, initial care plan development. This service must be delivered in person.

- **Ongoing Care Coordination Rate**

  For all subsequent months following the Health Action Plan payment, the Ongoing Care Coordination rate will be paid for eligible MI Care Team beneficiaries.

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the MI Care Team Handbook. (Refer to the Directory Appendix for website information.)

Payment for MI Care Team services is in addition to the existing fee-for-service payments, encounters, or daily rate payments for direct clinical services. MDHHS payment methodology is designed to only reimburse for the cost of MI Care Team staff for the delivery of Health Home services that are not covered by any other currently available Medicaid reimbursement mechanism.

7.8.B. Recoupment of Payment

The monthly payment is contingent on a MI Care Team beneficiary receiving a MI Care Team service during the month. The payment is subject to recoupment if the beneficiary does not receive a MI Care Team service during the calendar month. The recoupment lookback will occur four months after the monthly payment is made. Thus, four months after the month a payment is made (for example, in November, MDHHS would look back at July's payment), CHAMPS will conduct an automatic recoupment process that will look for an appropriate code. If a core MI Care Team service is not provided during a calendar month, that month's payment is subject to recoupment by MDHHS. Once a recoupment has occurred, there is no further opportunity to submit a valid MI Care Team encounter code and/or claim.

7.9. MI Care Team and Managed Care Beneficiaries

MI Care Team providers and Medicaid Health Plans are expected to work together to coordinate services for eligible members who wish to enroll in the MI Care Team benefit. Both the providers and the health plans will be given a list of their members deemed eligible for the MI Care Team program. MDHHS requires providers and health plans confer to optimize communication to beneficiaries. MI Care Team providers are primarily responsible for conducting outreach to eligible beneficiaries.

HEALTHY MICHIGAN PLAN

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Healthy Michigan Plan provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

Information contained in this chapter is to be used in conjunction with other chapters of this manual, including the Billing & Reimbursement Chapters as well as the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

1.1 ELIGIBILITY

The Healthy Michigan Plan provides health care coverage for individuals who:

- Are 19-64 years of age
- Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income (MAGI) methodology
- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

Eligibility for the Healthy Michigan Plan is determined through the MAGI methodology, coordinated through the Michigan Department of Health and Human Services (MDHHS). All criteria for MAGI eligibility must be met to be eligible for the Healthy Michigan Plan. For additional information on program eligibility, refer to the Beneficiary Eligibility Chapter of this manual.

1.2 BENEFIT ADMINISTRATION

All Healthy Michigan Plan beneficiaries, with the exception of some beneficiaries (e.g., Native Americans), are required to enroll in a health plan. Enrollees will select their health plan with assistance from MI Enrolls. In addition, behavioral health and substance use disorders will be administered in accordance with the current service delivery model.

1.2.A. MEDICAID HEALTH PLANS

MDHHS contracts with Medicaid Health Plans (MHPs) to provide services to Medicaid beneficiaries. MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)

Although MHPs must provide the full range of covered services, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization (PA) requirements and utilization management and review criteria that differ from Medicaid requirements.

1.2.B. Prepaid Inpatient Health Plans

Pursuant to Michigan's Medicaid State Plan and federally approved Section 1115 waiver, community-based mental health and substance use disorder services and supports are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).

1.2.C. Fee For Service

Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the fee-for-service (FFS) system. Providers must submit claims through the Community Health Automated Medicaid Processing System (CHAMPS).

Covered services that are carved out of the MHP and PIHP delivery systems will be reimbursed through FFS consistent with applicable Medicaid policy.

Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for FFS beneficiaries enrolled in the Healthy Michigan Plan mirror those required for Medicaid.

SECTION 2 – HEALTHY MICHIGAN PLAN AND HEALTHY BEHAVIORS

The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

2.1 INITIAL APPOINTMENT WITH PRIMARY CARE PROVIDER

Healthy Michigan Plan beneficiaries are required to contact their primary care provider within 60 days of enrollment in a health plan to schedule an appointment. When contacted by the beneficiary, providers are expected to make reasonable efforts to promptly schedule an initial appointment.

2.2 HEALTHY BEHAVIORS INCENTIVES

Healthy behaviors will be supported through access to primary care providers and healthy behavior promotion by health plans.

SECTION 3 – COST SHARING INFORMATION

The Healthy Michigan Plan has beneficiary cost-sharing obligations. Copayments may be required and due at the point of service for beneficiaries ages 21 years and older. The MDHHS Healthy Michigan Plan Copay Requirements table, available on the MDHHS website, provides detailed information regarding the specific services to which the copays may be applied. (Refer to the Directory Appendix for website information and the Beneficiary Eligibility chapter for information regarding cost sharing provisions.)

SECTION 4 – COVERAGE

The table below outlines beneficiary coverage under the Healthy Michigan Plan. Refer to the Special Coverage Provisions Section for additional coverage information.

Service	Coverage
Ambulatory patient services	▪ Primary care provider services ▪ Specialist/Referral care services ▪ Outpatient hospital services, including Ambulatory Surgical Center (ASC) services ▪ Home health care services ▪ Hospice care ▪ Podiatry care ▪ Chiropractic services
Emergency services	▪ Emergency room services ▪ Emergency transportation/ambulance ▪ Urgent Care Centers (UCC) or facilities
Hospitalization	▪ Inpatient hospital services (e.g., hospital stay, physician and surgical services)
Laboratory services	▪ Laboratory testing services
Maternity care	▪ Prenatal and postpartum care ▪ Delivery and inpatient services for maternity care
Mental health and substance use disorder services, including behavioral health treatment	▪ Mental/behavioral health inpatient services ▪ Mental/behavioral health outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services) ▪ Substance use disorder inpatient services (acute detoxification in medical setting) ▪ Substance use disorder outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services)
Pediatric services, including oral and vision care (19 and 20 year olds)	▪ General pediatric care ▪ Vision screening ▪ Eyeglasses and dental check-up services

Service	Coverage
Prescription drugs	▪ Prescription drugs and supplies. (Refer to the MDHHS website and the Pharmacy Benefits Manager (PBM) website for lists of prescription drugs that are carved-out of health plans. Providers must collect co-pays for these carved-out drugs at the point-of-sale. Refer to the Directory Appendix for website information.)
Preventive and wellness services and chronic disease management	▪ All United States Preventive Services Task Force grade A and B services ▪ Advisory Committee on Immunization Practices recommended vaccines ▪ Institute of Medicine recommended preventive services for women ▪ For 19 and 20 year olds, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as defined in the current periodicity schedule by the American Academy of Pediatrics (Additional information is available on websites for the organizations identified above. Refer to the Directory Appendix for website information.)
Rehabilitative and habilitative services and devices	▪ Inpatient rehabilitation services ▪ Outpatient rehabilitation and habilitative services ▪ Skilled Nursing Facility (consistent with 42 CFR §440.315(f)) ▪ Durable medical equipment, medical supplies, prosthetics and orthotics
Additional services	▪ Services provided in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) ▪ Non-Emergency Medical Transportation ▪ Family planning and reproductive health services and supplies ▪ Vision and optometrist services (e.g., eyeglasses, therapies, refractions) ▪ Hearing services (e.g., hearing aids and adjustments) ▪ Home Help services/personal care services ▪ Adult dental services ▪ Nursing facility services (consistent with 42 CFR §440.315(f)) ▪ Maternal Infant Health Program (MIHP) ▪ Program of All Inclusive Care for the Elderly (PACE) (consistent with 42 CFR §440.315(f)) ▪ Other covered services as defined in the Medicaid State Plan

SECTION 5 – SPECIAL COVERAGE PROVISIONS

This section provides general information regarding Healthy Michigan Plan coverage requirements for certain services. Additional information regarding these services may be contained in other relevant chapters of this manual, as applicable.

5.1 DENTAL

Refer to the General Information section of the Dental chapter for information on dental coverage.

5.2 HABILITATIVE SERVICES

Michigan adopted the National Association of Insurance Commissioners definition of habilitative services, which are described as services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy and speech-language pathology services provided in an outpatient hospital setting for people with disabilities.

5.2.A. COVERED SERVICES AND LIMITS

All services must be provided under the written order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or other qualified health professional as defined by law according to a written treatment plan established by that provider.

Physical and occupational therapy services provided in a private practice or outpatient setting will be limited to 144 units (15-minute increments) in a calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA.

Speech therapy services provided in a private practice or outpatient setting will be limited to 36 visits in a calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA.

The habilitative services modifier must be reported in addition to the procedure code for all habilitative services submitted either on PA requests or for claim adjudication to ensure proper payment. Refer to the Billing & Reimbursement chapters for additional therapy modifier information.

5.2.B. NON-COVERED SERVICES

Respite care, day care, recreational care, residential treatment, social services, custodial care, and services for vocational or educational purposes are not covered as habilitative services.

NOTE: Habilitative services provided as part of a mental health or substance use disorder person-centered planning process are subject to the Mental Health Specialty Services and Supports program criteria.

5.2.C. PRIOR AUTHORIZATION

When billing FFS, providers must obtain PA to continue therapy beyond the maximum benefit. Requests for PA must be submitted on the Occupational Therapy-Physical

Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix for additional information.)

PA requirements for beneficiaries enrolled in a health plan may differ from those described in this policy for FFS. Providers should contact the individual plans regarding their authorization requirements.

5.2.D. Place of Service

Habilitative services may be provided to beneficiaries of all ages by properly qualified and credentialed professionals in the outpatient hospital setting.

5.3 Behavioral Health Services

Healthy Michigan Plan beneficiaries have an array of behavioral health services available to treat mental health and substance use disorders.

5.3.A. Mental Health Services

Health plans will provide mental health services under the Mental Health Outpatient benefit consistent with the policies and procedures established by the traditional Medicaid Program. For mental health needs that do not meet established criteria, health plans must coordinate with the appropriate PIHP to ensure that medically necessary mental health services are provided. Refer to the Medicaid Health Plans and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual for additional information.

Beneficiaries who are not enrolled in a health plan will receive their outpatient mental health services through Fee-for-Service and may include Prepaid Inpatient Health Plan services as described in this manual.

Additional mental health services (e.g., inpatient hospitalization, intensive crisis stabilization, etc.) are covered benefits consistent with the policies and procedures established by the Medicaid program.

5.3.B. Behavioral Health Community-Based Specialty Services

This section applies to Behavioral Health supports and services providers. Behavioral Health, as referenced in this section, is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities. Information contained in this section is to be used in conjunction with other chapters of the Medicaid Provider Manual (e.g., the Billing & Reimbursement Chapters, the Practitioner Chapter and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) as well as the related procedure code databases located on the MDHHS website. (Refer to the Directory Appendix for website information.)

Pursuant to Michigan's Medicaid State Plan and federally approved Section 1115 waiver, community-based behavioral health supports and services are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).

The requirements and information found in the General Information Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter also apply to the provision of the Healthy Michigan Plan behavioral health supports and services.

In addition to the Definition of Terms found in the General Information Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, the following definitions are applicable to the Healthy Michigan Plan.

5.3.B.1. Definition of Terms

American Society of Addiction Medicine (ASAM) Criteria	The clinical guide designed by ASAM to improve assessment and outcomes-driven treatment and recovery services. It is also used to match patients to appropriate types and levels of care. In general, the purpose of the ASAM Criteria is to enhance the use of multidimensional assessments to develop patient-centered service plans and to guide clinicians, counselors, and care managers in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related, and co-occurring conditions.
Behavioral Health	A categorical description that is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities.
Behavioral Health Professional	For purposes of the Healthy Michigan Plan Chapter, this is a categorical description used to refer to the individuals who provide mental health and/or substance use disorder services that are identified in the Behavioral Health Code Charts and Provider Qualifications document on the MDHHS website. Refer to the Directory Appendix for website information.)
Covered Services	For purposes of the Healthy Michigan Plan chapter, Healthy Michigan Plan Specialty Behavioral Health Services.

5.3.B.2. Program Requirements

Refer to the Program Requirements Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. These requirements are consistent with the expectations for the Healthy Michigan Plan.

Additionally, as the Healthy Michigan Plan provides a behavioral health benefit, certain support services that are part of the Healthy Michigan Plan specialty behavioral health benefit do not require substance use disorder program licensure or accreditation to provide that service. Beneficiaries with a substance use disorder may receive these supports from a provider if the beneficiary meets the eligibility criteria outlined in each description. Those services are:

- Assistive Technology
- Community Living Supports
- Enhanced Pharmacy
- Environmental Modifications
- Fiscal Intermediary
- Housing Assistance
- Occupational Therapy

- Peer Specialist Services (recovery coach)
- Personal Care in Licensed Specialized Residential Care Settings
- Physical Therapy
- Respite Care
- Skill Building Assistance
- Support and Service Coordination
- Speech, Hearing and Language Therapy
- Transportation

5.3.B.3. COVERED SUPPORTS AND SERVICES

The following behavioral health supports and services are covered under the Healthy Michigan Plan. Supports and services with program changes specific to the Healthy Michigan Plan are explained in the following subsections. Information for supports and services marked with an * may be found in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.

The following supports and services are designed to assist those with physical, cognitive and/or functional impairments. These supports and services shall be provided to beneficiaries with a substance use disorder diagnosis who meet the medical necessity criteria in the identified area. The supports and services would be indicated as part of the beneficiary's plan of service.

Some interventions listed below (i.e., Assertive Community Treatment, Clubhouse, Hospital-Based Psychiatric Services, Intermediate Care Facilities, Peer Operated Drop In Centers and Supported Employment) are only indicated for a specified population (mental health or intellectual/developmental disability) and do not apply to those with a substance use disorder diagnosis, in which case beneficiaries would not be considered eligible for those services. Likewise, beneficiaries with a mental health or intellectual/developmental disability diagnosis would not be eligible for the services identified for substance use disorders (i.e., Residential, Sub-Acute Detoxification and Treatment Approved Pharmacological Supports).

- Assertive Community Treatment *
- Assessments *
- Assistive Technology *
- Behavior Treatment Review *
- Clubhouse Psychosocial Rehabilitation Programs *
- Community Living Supports *
- Crisis Services
- Enhanced Pharmacy *
- Environmental Modifications *
- Family Support and Training

- Fiscal Intermediary Services *
- Hospital-Based Psychiatric Services *
  (Refer to the Inpatient Psychiatric Hospital Admissions Section and the Outpatient Partial Hospitalization Services Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.)
- Housing Assistance *
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services *
- Medication Administration *
- Medication Review *
- Occupational Therapy *
- Outpatient Counseling and Therapy
- Peer-Delivered or Peer-Operated Support Services
- Personal Care in Licensed Specialized Residential Settings *
- Physical Therapy *
- Prevention-Direct Service Model
- Residential Substance Use Disorder Treatment *
  (Refer to the Residential Treatment subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.)
- Respite Care Services *
- Skill-Building Assistance *
- Speech, Hearing and Language *
- Sub-Acute Detoxification *
- Support and Service Coordination *
- Supported/Integrated Employment Services *
- Targeted Case Management
- Transportation *
- Treatment (DPT/CSAT) Approved Pharmacological Supports *
- Treatment Planning *

5.3.B.4. CRISIS SERVICES

Crisis Interventions	Crisis Interventions are unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy. The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, and one of the following applies:

	▪ The individual can reasonably be expected within the near future to physically injure themself or another individual, either intentionally or unintentionally; ▪ The individual is unable to provide themself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or ▪ The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the behavioral health professional, their continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual. If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.
Crisis Residential Services	Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may be used to avert an inpatient psychiatric admission or to shorten the length of an inpatient stay. Additionally, these services are designed for a subset of beneficiaries who meet the ASAM Criteria for Level 3.7 Medically Monitored Intensive Inpatient Services admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This service is also designed for beneficiaries who are intoxicated and at risk of admission to an acute setting or another level of care but can be appropriately served in this less intensive setting. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/individualized and recovery-oriented approach.

	▪ **Population:** Services are designed for a subset of beneficiaries who meet psychiatric inpatient/substance use disorder residential admission criteria or are at risk of admission to a high level of care setting but who can be appropriately served in a less intensive setting. ▪ **Covered Services:** Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiary to allow them to return to less intensive community living as soon as possible. Covered crisis residential services include: ➢ Psychiatric supervision (for programs providing mental health services and/or co-occurring disorders); ➢ Therapeutic support services; ➢ Medication management/stabilization and education; ➢ Behavioral services; ➢ Milieu therapy; and ➢ Nursing/medical services (on-site nursing services are required for those beneficiaries who are in the detoxification process, and who require medications to manage the current crisis). Beneficiaries who are admitted to crisis residential services must be offered the opportunity to explore and learn more about crises, mental health disorders, substance use disorders, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life, including relationships, where to live, training, employment, daily activities, and physical well-being. The program must include on-site nursing services (Registered Nurse [RN] or Licensed Practical Nurse [LPN] under appropriate supervision). ➢ For settings of 6 beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call. ➢ For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

- **Provider Criteria:** The PIHP must seek and maintain MDHHS approval for the crisis residential program in order to use Healthy Michigan Plan funds for program services. Healthy Michigan Plan crisis residential programs may choose to provide a program for serious mental illness, intellectual/developmental disabilities, substance use disorders or a combined program. A program offering services for substance use disorders must be licensed for residential substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. A combined program, one offering services for serious mental illness/intellectual and developmental disabilities and substance use disorders, must also be approved by MDHHS as a "co-occurring enhanced crisis residential program" (consistent with PA 338 of 2018). A co-occurring enhanced crisis residential program must be able to demonstrate that it can address the mental health needs, substance use disorder needs, or both of an individual through enhanced programming and staffing patterns. Established mental health residential programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/1915(i) SPA services do not require re-approval.
- **Qualified Staff:** Treatment services must be clinically supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone at all times. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process. Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times). Supervision must be by a behavioral health professional (Mental Health Professional [MHP] and/or a Substance Abuse Treatment Specialist [SATS] depending on the scope of services being provided) possessing at least a master's degree in human services and one year of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders; or a bachelor's degree in human services and at least two years of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders.

  Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing behavioral health services to individuals with mental illness and/or substance use disorders, or who have successfully completed a PIHP/ MDHHS-approved training program for working with individuals with mental illness and/or substance use disorders.

  Peer support specialists and/or recovery coaches may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer lead support groups, assisting in transitioning beneficiaries to less intensive services, and by mentoring beneficiaries towards recovery.

- **Location of Services:** Services must be provided to beneficiaries in licensed crisis residential foster care, group home settings not exceeding 16 beds in size, or in a licensed substance use disorder residential treatment program (when providing services for substance use disorders). Homes/settings must have appropriate licensure from the State and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.
- **Admission Criteria:** Crisis residential services may be provided to beneficiaries who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission or residential substance use disorder level of care criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental health or substance use disorders, beneficiaries with a co-occurring mental health and substance use disorder, or beneficiaries with intellectual/developmental disabilities. For beneficiaries with a concomitant disorder with an intellectual/developmental disability, the primary reason for service must be mental illness or substance use disorder.
- **Duration of Services:** Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team. For substance use disorders, beneficiaries should be moved to another ASAM Level of Care within 14 days; however, services may be extended if justified by clinical need, medical necessity, and as determined by the interdisciplinary team.
- **Individual Plan of Service/Treatment Plan:** Services must be delivered according to an Individual Plan of Service (IPOS) or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) based on an assessment of immediate need. The IPOS/treatment plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the guardian, the psychiatrist, and any other professionals involved in the treatment planning process as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

  The IPOS/treatment plan must contain:

  - Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis;
  - Identification of the activities designed to assist the beneficiary to attain their goals and objectives; and
  - Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual Assertive Community Treatment (ACT) team, outpatient services provider, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days according to need.)

Intensive Crisis Stabilization Services	Individuals between 19-21 years of age could be served under EPSDT utilizing the intensive crisis stabilization team for children. (Refer to the Intensive Crisis Stabilization Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.) Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services and/or substance use disorder residential treatment in a community setting. Services may be used to avert a psychiatric admission, residential substance use disorder admission, or to shorten the length of an inpatient or substance use disorder residential stay when clinically indicated. Crisis situation means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, and one of the following applies: ▪ The individual can reasonably be expected within the near future to physically injure themself or another individual, either intentionally or unintentionally; ▪ The individual is unable to provide themself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or ▪ The individual's judgment is so impaired that they are unable to understand the need for treatment and, in the opinion of the behavioral health professional, their continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual. ▪ **Approval:** The PIHP must seek and maintain MDHHS approval for the intensive crisis stabilization services in order to use Healthy Michigan Plan funds for program services. A program that will be offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Established crisis stabilization service programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/1915(i) SPA services do not require re-approval. ▪ **Population:** These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions and/or substance use disorder residential/inpatient treatment but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services and/or substance use disorder residential/inpatient treatment if such services will result in a shortened stay. Beneficiaries must have a diagnosis of mental illness, substance use disorder or mental illness with a co-occurring substance use disorder, or intellectual/developmental disability.

- **Services:** Intensive crisis stabilization services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:
  - Intensive individual counseling/psychotherapy;
  - Assessments (rendered by the treatment team);
  - Family therapy;
  - Psychiatric supervision; and
  - Therapeutic support services by trained paraprofessionals.
- **Qualified Staff:** Intensive crisis stabilization services must be provided by a treatment team of behavioral health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. The treatment team providing intensive crisis stabilization services must be Mental Health Professionals and/or Substance Abuse Treatment Specialists. Nursing services/consultation must be available.

  The treatment team may be assisted by trained paraprofessionals under appropriate supervision. Trained paraprofessionals must have at least one year of satisfactory work experience providing services to individuals with behavioral health disorders. Activities of trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists and/or recovery coaches.
- **Location of Services:** Intensive crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, their usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

  Exceptions: Intensive crisis stabilization services may not be provided in:
  - Inpatient settings;
  - Jails or other settings where the beneficiary has been adjudicated; or
  - Crisis residential settings.
- **Individual Plan of Service/Treatment Plan:** Intensive crisis stabilization services may be provided initially to alleviate an immediate behavioral health crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services IPOS or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) must be developed. The intensive crisis stabilization IPOS/treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

	The IPOS/treatment plan must contain: ➢ Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances structured to resolve the crisis. ➢ Identification of the services and activities designed to resolve the crisis and attain the beneficiary's goals and objectives. ➢ Plans for follow-up services (including other behavioral health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

5.3.B.5. FAMILY SUPPORT AND TRAINING

Family-focused services are provided to the family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of beneficiaries with behavioral health disorders for the purpose of assisting the family in relating to and caring for a relative with a behavioral health disorder. The services target the family members who are caring for and/or living with the beneficiary who is receiving behavioral health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in their ability to achieve goals of:

- Performing activities of daily living;
- Perceiving, controlling, or communicating with the environment in which they live; or
- Improving their inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's IPOS/treatment plan, along with the beneficiary's goals that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the beneficiary at home as specified in the IPOS/treatment plan.
- Counseling and peer support provided by an appropriately trained counselor or appropriately trained peer. This can be in a one-on-one or group setting to provide assistance with identifying coping strategies for successfully caring for or living with a person who has a behavioral health disorder.
- Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.

5.3.B.6. Outpatient Counseling and Therapy

Outpatient counseling and therapy is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed behavioral health treatment or in a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary and determined by individual need, can total over 20 hours in a week. Individual, family or group treatment services may be provided separately or in combination.

Treatment must be person-centered/individualized based on an appropriate assessment/evaluation and contain a diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on medical necessity and/or the ASAM Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery. Referral, continuing stay, and recovery support needs must be identified through the person-centered/individualized treatment planning process.

Provider Qualifications	Substance use disorder outpatient service providers are required to be licensed as an organization. A program offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Substance use disorder outpatient providers offering the adjunct support services of case management, early intervention, integrated treatment for persons with mental health and substance use disorders, and/or peer recovery and recovery support must have these areas added to their outpatient substance use disorder license as approved service categories. All behavioral health organizations/providers of outpatient services must have appropriately licensed and credentialed staff and provide treatment that is within their established scope of practice. (Refer to the Behavioral Health Code Charts and Provider Qualifications document that supports the Medicaid Provider Manual. The Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. Refer to the Directory Appendix for website information.)
Eligibility	Outpatient counseling and therapy may be provided only when: ▪ The service meets medical necessity criteria; ▪ It meets the person-centered service planning requirement; ▪ The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis); ▪ The service is based on individualized determination of need through the state established needs-based criteria; ▪ The service is cost effective; ▪ The ASAM Criteria are used in the determination of substance use disorder treatment placement/admission and/or continued stay needs; and

	▪ The substance use disorder service is supported by a level of care determination using the six assessment dimensions of the current ASAM Criteria: ➢ Withdrawal potential; ➢ Medical conditions and complications; ➢ Emotional, behavioral or cognitive conditions and complications; ➢ Readiness to change; ➢ Relapse, continued use, or continued problem potential; and ➢ Recovery/living environment. This service is limited to those beneficiaries who will benefit from treatment and have been determined to have: ▪ An acceptable readiness to change level; ▪ Minimal or manageable medical conditions; ▪ Minimal or manageable withdrawal risks; ▪ Emotional, behavioral and cognitive conditions that will not prevent the beneficiary from benefiting from this level of care; ▪ Minimal or manageable relapse potential; and ▪ A minimally to fully supportive recovery environment.
Allowable Services	Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following behavioral health services can be provided in the outpatient setting. ▪ **Individual Assessment:** A face-to-face service for the purpose of identifying functional, treatment, and recovery needs of a behavioral health disorder and a basis for formulating the person-centered/individualized treatment planning process. ▪ **Individual Treatment Planning:** Refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. ▪ **Individual Therapy:** Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices, such as Integrated Dual Disorder Treatment for Co-Occurring Disorders (IDDT/COD) and Dialectical Behavior Therapy (DBT), are included in this coverage. Individual therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

	▪ **Group Therapy:** Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities. Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices (such as IDDT/COD and DBT) are included in this coverage. Group therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. (Refer to the Directory Appendix for website information.) ▪ **Family Therapy:** Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. Refer to the Directory Appendix for website information.) ▪ **Crisis Intervention:** Refer to the Crisis Interventions subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. ▪ **Referral/Linking/Coordinating/Management of Services:** For the purpose of providing adjunct support for ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment, and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary. ▪ **Peer Support Specialist/Recovery Coach and Recovery Support:** For the purpose of providing adjunct support to outpatient services. Refer to the Peer-Delivered or Peer-Operated Support Services subsection of this chapter for additional information. ▪ **Compliance Monitoring:** For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing). Also includes tracking the appropriate use of prescribed medications. ▪ **Early Intervention:** Includes stage-based interventions for beneficiaries with substance use disorders and beneficiaries who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. ▪ **Detoxification/Withdrawal Monitoring:** For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance. ▪ **Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT) Approved Pharmacological Supports:** Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.

Admission Criteria	Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently. Reauthorization of services can be denied in situations where the beneficiary has: ▪ Not been actively involved in their treatment, as evidenced by repeatedly missing appointments; ▪ Not been participating/refused to participate in treatment activities; or ▪ Continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services. Beneficiaries may also be terminated from treatment services based on these violations.
Level of Care Criteria for Substance Use Disorders	Medically necessary outpatient services for beneficiaries with substance use disorders correspond to the frequency and duration of services established by the ASAM criteria and are referred to as follows: ▪ Level 0.5 – Early Intervention ▪ Level 1 – Outpatient ▪ Level 2.1 – Intensive Outpatient ▪ Level 2.5 – Partial Hospitalization Services Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan, and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary's needs increase, more services and/or frequency/duration of services may be utilized if these are medically necessary. The ASAM criteria correspond with established hours of services that take place during a week. ▪ ASAM Level 0.5: Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary's motivation to change and other risk factors that may be present. ▪ ASAM Level 1: Services from one hour to eight hours during a week. ▪ ASAM Level 2.1: Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment. ▪ ASAM Level 2.5: Services that are offered 20 or more hours in a week. The medically necessary outpatient services for beneficiaries with a mental illness and/or a concomitant substance use disorder or intellectual/developmental disability correspond with the frequency and duration of the evidenced-based practice, promising practice, or the specialty-focused service provided. The guidelines for these practices, along with the individual needs of the beneficiary, will establish the frequency, duration, and type of treatment service.

5.3.B.7. Peer-Delivered or Peer-Operated Support Services

Peer-delivered or peer-operated support services are programs and services that provide beneficiaries with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

Peer specialist and recovery coach services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing behavioral health supports and services to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experiences and perspectives with disabilities, and with planning and negotiating human services systems.

- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs of room and board utilizing an individual budget; purchasing a home; etc. (reported as Supports Coordination).
- Supports and services planning and utilization assistance provides assistance and partnership in:
  - The person-centered planning process (reported as either Treatment Planning or Supports Coordination);
  - Developing and applying arrangements that support self-determination;
  - Directly selecting, employing or directing support staff;
  - Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
  - Accessing entitlements;
  - Developing health and wellness plans;
  - Developing advance directives;
  - Learning about and pursuing alternatives to guardianship;
  - Providing supportive services during crises;
  - Developing, implementing and providing ongoing guidance for advocacy and support groups;
  - Integration of physical and mental health care; and
  - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.

Activities provided by peer specialists are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, recovery and productivity.

Peer Support Specialist and Recovery Coach Services	Individuals providing Peer Support Services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those who are generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. Individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness must: ▪ Have a serious mental illness; ▪ Have received public mental health services in the past or are currently receiving services; ▪ Provide at least 10 hours per week of services described above, with supported documentation written in the IPOS/treatment plan; and ▪ Meet the MDHHS application approval process for specialized training and certification requirements. Individuals who are functioning as a Recovery Coach serving beneficiaries with a substance use disorder must: ▪ Have a minimum of two years of recovery from a substance use disorder; ▪ Receive specialized training and certification approved by MDHHS; ▪ Be employed through a substance use disorder treatment program or a Recovery Community Organization under contract with the PIHP; and ▪ Recognize that there are many pathways to recovery.
Drop-In Centers	Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of beneficiaries. PIHPs must seek approval from MDHHS prior to establishing new drop-in programs. Programs currently approved to provide services by MDHHS through the delivery of Medicaid State Plan, HSW, or additional/1915(i) SPA services do not require re-approval. Proposed drop-in centers will be reviewed against the following criteria: ▪ Staff and board of directors of the center are 100% primary consumers; ▪ PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program; ▪ PIHP facilitates consumers' ability to handle the finances of the program; ▪ The drop-in center is at a non-CMH site; ▪ The drop-in center has applied for 501(c)(3) non-profit status;

	▪ There is a contract between the drop-in center and the PIHP or its subcontractor identifying the roles and responsibilities of each party; and ▪ There is a liaison appointed by the PIHP to work with the program. Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in service specified in their IPOS, it must be documented to be medically necessary and identify: ▪ Goals and how the program supports those goals; and ▪ The amount, scope and duration of the services to be delivered. The individual clinical record provides evidence that the services were delivered consistent with the plan.

5.3.B.8. PREVENTION-DIRECT SERVICE MODEL

Children of Adults with Behavioral Health Disorders/ Integrated Services	Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the specialty behavioral health service system and to improve outcomes for beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the beneficiary related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the IPOS/treatment plan through a person centered planning process for the beneficiary who is a parent. Linking the beneficiary and child to available community services, respite care, and providing for crisis planning are essential components. Provider qualifications: ▪ Mental Health Professional; and/or ▪ Substance Abuse Treatment Specialist.

5.3.B.9. TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all Healthy Michigan Plan beneficiaries with a behavioral health disorder who have multiple service needs, have a high level of vulnerability, require access to a continuum of behavioral health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

Provider Qualifications	Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population. Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served. Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the IPOS developed through the person-centered planning process. Additionally, providers serving beneficiaries with a substance use disorder must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Abuse Services, with the case management service category and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. If a program is serving beneficiaries with a co-occurring mental health and substance use disorder, the outpatient license must also have the added service category of "integrated treatment for persons with mental health and substance use disorders". Established targeted case management programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/1915(i) SPA services do not require re-approval.
Determination of Need	The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving supports and services. Justification as to whether case management is needed or not must be documented in the beneficiary's case record.
Core Requirements	Targeted case management services must: ▪ Assure that the person-centered planning process takes place and that it results in the development of the IPOS/treatment plan; ▪ Assure that the IPOS/treatment plan identifies what supports and services will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the supports and services identified under each goal and objective; ▪ Oversee implementation of the IPOS/treatment plan, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports; ▪ Assure the participation of the beneficiary on an ongoing basis in discussions of their plans, goals, and status; ▪ Identify and address gaps in service provision; ▪ Coordinate the beneficiary's supports and services with all providers, make referrals, and advocate for the beneficiary; ▪ Assist the beneficiary to access programs that provide financial, medical, and other assistance, such as Home Help and Transportation services; ▪ Assure coordination with the beneficiary's primary and other health care providers to assure continuity of care; ▪ Coordinate, and assist the beneficiary in, crisis intervention and discharge planning, including community supports after hospitalization;

	▪ Facilitate the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services; ▪ Assist the beneficiary with crisis planning; and ▪ Identify the process for after-hours contact.
Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The IPOS/treatment plan must also reflect such changes.
Documentation	The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location/type of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs. The case manager must review services at intervals defined in the IPOS/treatment plan. The IPOS/treatment plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or their guardian or authorized representative may request and review the IPOS/treatment plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.
Monitoring	The case manager must determine, on an ongoing basis, if the supports and services have been delivered and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the IPOS/treatment plan. Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training or provision of Medicaid services. Targeted case managers are prohibited from exercising the funding agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.
Staff Qualifications	A primary case manager for beneficiaries with a mental health or intellectual/developmental disability must be a Qualified Mental Health Professional (QMHP) or Qualified Intellectual Disabilities Professional (QIDP); or, if the case manager has only a bachelor's degree but is without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. A primary case manager for beneficiaries with a substance use disorder must be appropriately trained and supervised by a SATS. For beneficiaries with concomitant behavioral health disorders, the case manager must have the appropriate training or experience and/or be supervised by someone who does possess the training or experience for the concomitant disorder in question.

HEARING SERVICES AND DEVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to audiology providers, hearing aid dealers, and cochlear implant manufacturers. Information contained in this chapter is to be used in conjunction with other chapters of this manual, including the Billing & Reimbursement chapters, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

Medicaid covers audiology services and devices, including hearing tests, diagnostic services, auditory rehabilitation, hearing aids, cochlear implants, and bone anchored hearing devices (BAHDs), when ordered/referred by a Medicaid enrolled physician or qualified non-physician practitioner (i.e., physician assistant (PA) or advanced practice registered nurse (APRN)). Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment, or orthotics/prosthetics.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to Children's Special Health Care Services (CSHCS)-only beneficiaries.

1.1 PROVIDER REQUIREMENTS

1.1.A. LICENSED AUDIOLOGISTS

Licensed audiologists may enroll with Medicaid for reimbursement of audiology and hearing aid services. Out-of-state audiologists must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter for more information.)

Services performed by licensed audiologists must be provided at the service/practice address identified on the Medicaid provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.B. COCHLEAR IMPLANT MANUFACTURERS

Cochlear implant manufacturers may enroll with Medicaid for reimbursement of cochlear implant and BAHDs, parts, accessories, and repairs. Manufacturers must be licensed in the state in which they conduct business if that state requires licensure.

1.1.C. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Agencies (Rehab Agencies) may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. All CORFs and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.

Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.D. Hearing Aid Dealers

Hearing aid dealers licensed in the state of Michigan and conforming to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13) may enroll with Medicaid for reimbursement of hearing aid devices and services. This provider type must enroll as a Facility/Agency/Organization with a Type 2 (Organization) Billing National Provider Identifier (NPI).

1.1.E. Hearing Centers

Freestanding hearing centers may enroll with Medicaid for reimbursement of audiology services. The freestanding hearing center must not be part of, or owned by, a hospital, CORF, Rehab Agency, or university graduate education program.

1.1.F. Independent Diagnostic Testing Facilities

Medicare certified Independent Diagnostic Testing Facilities (IDTFs) may enroll with Medicaid for reimbursement of audiology related diagnostic testing services. The IDTF must be an independent facility not associated with a physician's office or hospital. Refer to the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapter for information and requirements related to IDTFs.

1.1.G. Medical Supplier

Medical Suppliers may enroll with Medicaid for reimbursement of disposable hearing aid batteries. Refer to the Medical Supplier chapter for information and requirements related to Medical Suppliers.

1.1.H. Outpatient Hospital

Audiology services may be provided to beneficiaries in the outpatient hospital.

1.1.I. Physicians and Clinics

A physician, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department that provides hearing services may enroll with Medicaid for reimbursement.

1.1.J. University Affiliated Audiology Graduate Education Programs

University affiliated audiology graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) or doctor of audiology programs accredited by the American Academy of Audiology (AAA) Accreditation Commission for Audiology Education (ACAE) may enroll with Medicaid for reimbursement of audiology

services provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF, or Rehab Agency. All university programs must provide proof of their current ASHA-CAA or AAA-ACAE when enrolling in Medicaid.

1.1.K. Speech-Language Pathologists

Speech-Language Pathologists (SLPs) may enroll with Medicaid for reimbursement of audiological rehabilitation and speech-language therapy services. SLPs must possess a current license and/or be certified by the appropriate standard-setting authority in the state in which they are practicing. Refer to the Therapy Services chapter for information and requirements related to SLPs.

1.2 Healthcare Common Procedure Coding System Codes, Parameters and Modifiers

Providers should refer to the current edition of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) manuals published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require prior authorization (PA).

For specifics regarding the HCPCS and CPT codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.)

The "LT" or "RT" modifier must be reported for all earmolds, sound processors, devices (including monaural hearing aids, BAHDs, and cochlear implants), and monaural dispensing services to designate either the left or right side of the body. When the same service is provided for both the left and right ears on the same date of service (DOS), the service should be reported on two separate claim lines with the appropriate modifier on each line.

1.3 Documentation in Beneficiary File

Hearing services providers must maintain all applicable documentation in the beneficiary's file for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the item or service supplied.

1.4 CSHCS Requirements

The following information is regarding beneficiaries who are enrolled in CSHCS only. These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

Once a beneficiary is enrolled in the CSHCS program for a condition that requires audiology services, a pediatric subspecialist is authorized by CSHCS to serve the beneficiary. CSHCS does not cover audiology services that are unrelated to the beneficiary's qualifying diagnosis. Prescriptions for hearing devices and supplies must be signed by the authorized subspecialist.

The pediatric subspecialist coordinates hearing treatment and services relating to the beneficiary's CSHCS qualifying diagnosis. However, a diagnostic evaluation by an audiologist does not require a referral by the pediatric subspecialist. Before billing for audiology services, the enrolled provider(s) must verify that they have been authorized to provide services to the beneficiary. (Refer to the Children's Special Health Care Services chapter for further CSHCS information.)

1.5 Copayments

A copayment for a hearing aid may be required for beneficiaries age 21 years and older. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

When calculating reimbursement, Medicaid deducts the copayment from the amount approved, when applicable. If the provider deducts the copayment from their claim, an underpayment results. Addition of the copayment amount to the acquisition cost is not allowed.

Refer to the Billing Beneficiaries section of the General Information for Providers chapter of this manual for additional information regarding copayment requirements.

1.6 Practitioner Signatures

In all documentation requiring a signature, the signature must be handwritten by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.7 Reimbursement

Reimbursement is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System (OPPS) and Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System [CHAMPS] or the MDHHS Hearing Services and Hearing Aid Dealers Fee Schedules on the MDHHS website.) For NOC codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved PA request.

The date of delivery of the hearing aid must be reported as the DOS. When there is a loss of eligibility or a change in eligibility status between the time a hearing aid is ordered and delivered, the DOS should be reported as the order date rather than the delivery date.

1.8 Other Insurance

If the beneficiary has another insurance plan (e.g., Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s) including, but not limited to, prescription, PA, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

SECTION 2 – COVERAGE OVERVIEW

2.1 SERVICE PROVIDERS

Audiology services may be provided by Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers in the following settings:

- Hospital
- Hearing Center
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Outpatient Rehabilitation Agency
- CAA or AAA Accredited University Affiliated Audiology Graduate Education Program
- Licensed Audiologist Office/Clinic
- Physician's Office/Clinic including, but not limited to, a Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.
- Independent Diagnostic Testing Facility

Audiology services and hearing aid evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing their post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing their clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist

Hearing aid selection, fitting, and conformity evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing their post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing their clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist
- Hearing Aid Dealer

2.2 DIAGNOSTIC AND AMPLIFICATION SERVICES

The following diagnostic and amplification services may be provided to all eligible beneficiaries:

- Air and/or bone conduction audiogram
- Basic hearing evaluation (includes pure-tone audiometry, speech audiometry and report)

- Diagnostic audiologic evaluations
- Earmold fabrication
- Electroacoustic analysis of hearing aid
- Aided performance assessment with the beneficiary's hearing aid
- Hearing aid evaluation and selection
- Hearing aid orientation/training or hearing therapy

Standards of practice must conform to those published in the current version of ASHA's Preferred Practice Patterns for the Profession of Audiology or AAA's Standards of Practice for Audiology. Audiologic test equipment and hearing aid test equipment used must conform to current, applicable American National Standards Institute (ANSI) criteria.

2.3 Newborn Hearing Services

All Medicaid-covered newborns must be screened using the auditory brainstem response (ABR) method and/or the evoked otoacoustic emissions (EOAE) method. Audiology newborn hearing screening tests must be performed by staff trained in the screening of infant hearing via the ABR or EOAE method. Medicaid requires appropriate interaction with parents/guardians and the medical team, and the proper reporting of hearing results with the MDHHS monitoring program.

Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. If the birthing facility is not equipped for ABR or EOAE, the child's APRN, physician, or PA must refer the newborn to an audiologist or hearing center for screening prior to one month of age.

Equipment must be available to audiologists providing a comprehensive diagnostic evaluation to infants less than six months of age. Infant evaluation services include, but are not limited to:

- Tone Burst ABR or Auditory Steady State Response (ASSR) Test
- Click ABR
- Bone Conduction ABR
- High Frequency Acoustic Immittance Measures
- Otoacoustic Emissions

Equipment must be available to audiologists providing hearing aid evaluation, selection, and follow-up services to infants less than six months of age. Infant hearing aid services include, but are not limited to:

- Infant Predictive Method (e.g., Desired Sensation Level)
- Real-Ear to Coupler Difference

Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.

2.4 Hearing Aid Services and Supplies

Medicaid covers hearing aid devices, repairs, earmolds, batteries, supplies, and accessories provided by a Medicaid enrolled licensed hearing aid dealer or audiologist. Batteries may also be provided by an enrolled Medical Supplier.

Hearing aids are only a benefit when:

- The recommended hearing aid meets United States Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements;
- Medical documentation indicates that the conductive hearing loss is not transient in nature due to a treatable medical middle ear effusion or that surgery is not planned within the next year;
- The beneficiary has not received a Medicaid covered hearing aid(s) within the last five years;
- A manufacturer's warranty of 24 months covering parts and labor and a 12-month warranty covering loss or damage are included. These warranties apply to all hearing aids, including those not covered under the MDHHS volume purchase contract.

MDHHS participates in a volume purchase contract agreement for hearing aid devices. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers should refer to the Hearing Aids section of this chapter for complete information on hearing aid services and devices.

2.5 Assistive Listening Devices

An Assistive Listening Device (ALD) is a benefit when the patient management of a personal hearing aid is considered unrealistic or the frequency specific audiometric data cannot be obtained in each ear. The ALD is provided for situations involving one-on-one conversation and is not designed primarily for recreational or educational use. An ALD is covered when Medicaid has not covered any hearing aid(s) or ALD dispensed to the beneficiary within the last three years. Providers should refer to the Other Hearing Devices section, Assistive Listening Devices subsection of this chapter for additional information.

2.6 Speech Services

Evaluation and treatment of speech, language, cognition, voice, and auditory processing is covered when performed by a SLP. Refer to the Therapy Services chapter for information and requirements related to speech therapy services.

2.7 Auditory Rehabilitation

Auditory rehabilitation is covered when medically necessary for beneficiaries who have received an implanted hearing device, hearing aid, or who have pre-lingual or post-lingual hearing loss. Auditory rehabilitation services are designed to optimize the benefit provided by the hearing device and improve the communication relationships affected by the beneficiary's loss of hearing. Aural rehabilitation focuses on auditory signal utilization, speech perception, and communication and listening skills development.

Auditory rehabilitation can be provided by a licensed audiologist or SLP who has training and expertise in the procedures. Evaluations for auditory rehabilitation may be provided up to two times per year, and a

maximum of 36 visits per year of aural rehabilitation are allowed. SLPs should refer to the Therapy Services chapter for documentation requirements. If additional visits are needed, PA is required.

2.8 Cochlear Implants

Cochlear implantation and associated mapping/calibration are covered and reimbursable under Medicaid and CSHCS programs for eligible beneficiaries using FDA approved implants. Cochlear implants are covered with PA for beneficiaries with pre- or post-lingual deafness who meet the implantation criteria. Providers should refer to the Other Hearing Devices section, Cochlear Implants subsection of this chapter for complete information.

2.9 Bone Anchored Hearing Devices

Medicaid covers FDA approved implantable and non-implantable BAHDs as an assistive hearing instrument for those who can benefit when there is no other suitable aid. Beneficiaries must have a unilateral or bilateral conductive or mixed hearing loss, or a unilateral profound sensorineural hearing loss. Providers should refer to the Other Hearing Devices section, Bone Anchored Hearing Devices subsection of this chapter for additional information.

SECTION 3 – PRIOR AUTHORIZATION

PA is required for certain services before the services are rendered. To determine which service requires PA, refer to the prior authorization subsections throughout this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

PA is required for the following situations:

- Services or devices for which the beneficiary does not meet the Medicaid Standards of Coverage as outlined in this policy
- Any hearing aids that are not covered under the MDHHS volume purchase contract
- ALDs
- Cochlear implant devices or processors (unilateral or bilateral)
- BAHDs or processors (bilateral only)
- Services and items that exceed quantity limits, frequency limits, or established fee screens
- Use of a NOC code

3.1 PRIOR AUTHORIZATION FORM AND COMPLETION INSTRUCTIONS

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram, and hearing aid recommendation from an audiologist) must accompany the MSA-1653-B.

Providers requesting PA for items without an established fee screen must also include a copy of the manufacturer's invoice that lists the acquisition cost for the item. Manufacturer quotes or dealer list prices are not accepted as documentation of the cost. Modified manufacturer invoices will not be accepted. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of $0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing.

The information on the MSA-1653-B must be:

- Typed – All information must be clearly typed in the designated boxes of the form;
- Thorough – Complete information, including manufacturer, model, and style of the hearing device requested (if applicable), and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The MSA-1653-B and all documentation must include the beneficiary's name and **mihealth** card identification (ID) number, provider name, address, and National Provider Identification (NPI) number.

A sample of the MSA-1653-B with additional instructions is available in the Forms Appendix of this manual.

For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-1653-B must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a PA request in CHAMPS or by

contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

PA requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-1653-B must be attached to each electronic PA request.

A copy of the PA determination letter must be retained in the beneficiary's medical record.

3.2 Retroactive Prior Authorization

Hearing services or devices provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive PA will be denied.

3.3 Beneficiary Eligibility

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. Approval of a PA request does not guarantee beneficiary eligibility or payment. To assure payment, it is recommended providers verify the beneficiary's eligibility on the DOS. Providers should refer to the Beneficiary Eligibility chapter of this manual for additional information.

3.4 Reimbursement Amounts

Many items have established fee screens that are published in the MDHHS Hearing Services or Hearing Aid Dealers Fee Schedules. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized MSA-1653-B.

3.5 Billing Authorized Services

After PA is issued, the information (e.g., PA number, HCPCS/CPT code, modifier, and quantity) that was approved must match the information submitted on the claim form. (Refer to the Billing & Reimbursement chapters of this manual for complete billing instructions.)

SECTION 4 – HEARING AIDS

4.1 DEFINITIONS

The following definitions are used for purposes of administering and clarifying Medicaid coverages and limitations for hearing aid dealers:

Hearing Aid	A hearing aid is a wearable instrument or device designed to deliver amplified sound in order to compensate for a hearing loss. Models include body worn, behind the ear, in the ear, in the canal, and bone conduction. The hearing aid usually consists of a microphone, an amplifier, and a receiver.
Contralateral Routing System Hearing Aid	A hearing aid with a microphone worn on an unaidable ear with a receiver or additional microphone worn on the better ear.
Digital Hearing Aid	A hearing aid that uses digitized sound processing (DSP) to convert sound waves into digital signals.

4.2 COVERED SERVICES AND ITEMS

Medicaid covers the following services and items when medically necessary and provided by a licensed hearing aid dealer, hearing center, or audiologist.

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Assistive listening devices (ALDs)

Disposable hearing aid batteries may also be provided by a medical supplier.

4.3 NONCOVERED SERVICES AND ITEMS

Noncovered services and items include, but are not limited to, the following:

- Hearing aids that do not meet FDA requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics

- Devices (i.e., hearing aids and non-surgical BAHDs) ordered for eligible beneficiaries but delivered more than 30 days after a beneficiary became ineligible for Medicaid
- Services rendered or devices dispensed before PA is approved
- Services or devices required to be provided by another public agency or program (e.g., school-based services, etc.)

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.

4.4 Hearing Aid Contract

MDHHS participates in a volume purchase contract agreement for hearing aids. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers must bill and are reimbursed the contract price for the hearing aid which cannot be further reduced or altered.

4.5 Medical Clearance

A medical clearance is a written statement signed by the physician, physician assistant, or advanced practice registered nurse indicating that:

- A medical evaluation was performed within six months prior to the beneficiary obtaining a hearing aid; and
- There are no contraindications to the use of a hearing aid.

For Medicaid beneficiaries under age 18, a Medicaid enrolled otolaryngologist or other appropriate specialty physician must complete the medical clearance.

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by a Medicaid enrolled primary care provider, otolaryngologist, or other appropriate specialty care provider.

The medical clearance must include the beneficiary's name, birth date, address, **mihealth** card identification (ID) number, the services provided, the DOS, the provider's name, and provider NPI number.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The hearing aid prescription must be related to the CSHCS qualifying diagnosis.
- The otolaryngologist signing the medical clearance must be a CSHCS enrolled provider.

4.6 Evaluation and Selection

Audiologists may perform hearing aid evaluations and selections with medical concurrence from the primary care provider, otolaryngologist, or other appropriate specialty care provider. After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid, a recommendation for the hearing aid must be completed and signed by the audiologist.

The recommendation, as well as a copy of the medical clearance, is given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. Beneficiaries must be given freedom of choice of any Medicaid-enrolled hearing aid dealer when obtaining their hearing aid, even when the licensed audiologist is also enrolled with Medicaid to dispense hearing aids.

4.7 Measurable Benefits/Conformity Evaluations

Any delivered hearing aid is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by one, or a combination of, commonly used procedures, including:

- Measures of aided hearing and understanding of speech;
- Functional gain measures;
- Probe-microphone measurements; and/or
- (Minimally) the subjective impressions of the beneficiary, the beneficiary's family members or guardian, or attending staff.

Benefit may be demonstrated in cases of severe to profound hearing loss by at least one of the following measures:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved word recognition performance at average or slightly raised conversational levels with or without visual cues.
- Beneficiary's or family member's subjective report of speech benefit in everyday listening situations.

Hearing aid dealers must instruct beneficiaries to return to the evaluating audiologist for the conformity evaluation to allow for the return of the device, if necessary, within 90 days of the hearing aid dispensing date. When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 90 days for modifications, remake, exchange, or credit as recommended by the evaluating audiologist. The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.

All full or partial refunds made by a manufacturer to the hearing aid dealer when a hearing aid is returned within the 90-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

A conformity evaluation for verification and validation of a hearing aid's benefit and performance provided on the same date of service as the dispensing fee will not be separately reimbursed. Hearing aid conformity evaluations for beneficiaries with an existing hearing aid may be provided up to a maximum of two times per year without PA.

4.8 Dispensing Fee

The hearing aid dealer may bill a dispensing fee when providing direct patient contact in delivering, fitting, and orientating beneficiaries on the use and care of the hearing aid. This fee applies to both

digital or contralateral routing system models purchased through the Medicaid volume purchase contract agreement and noncontracted hearing aids. The dispensing fee covers all services and products listed below for a period of 90 days unless otherwise noted.

- Hearing aid delivery. Packing, shipping, and handling are provided by the hearing aid manufacturer at no cost to the dispensing provider.
- Initial and follow-up care for hearing aid set up and management. Services include, but are not limited to, electroacoustic assessments, programming or setting of internal device controls, device inspections, cleanings, physical fit adjustments, and accessory pairing.
- Initial and follow-up hearing aid education. Services include, but are not limited to, orientation, education, and instruction on use, care, and maintenance of the device.
- One 90-day supply of disposable batteries per aid (non-rechargeable models).
- All components necessary for the hearing aid's operation. These are generally provided by the hearing aid manufacturer and include items such as rechargeable batteries, chargers, cords, tubing, connectors, or receivers.
- A 90-day trial/adjustment period with exchange/return privilege. This warranty is provided by the hearing aid manufacturer at no cost to the dispensing provider.

The dispensing fee should be billed separately from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. Earmolds and hearing aid supplies and accessories not provided by the manufacturer may be billed separately from the dispensing fee.

Providers may not receive a dispensing fee for hearing aids returned during the 90-day trial period. Any dispensing fees paid to providers for hearing aids subsequently returned during the 90-day trial period must be returned to MDHHS via a claim replacement. If the hearing aid is returned, MDHHS will reimburse for the hearing aid fitting/checking visit.

4.9 Mandatory Manufacturer's Warranty

Medicaid requires that all hearing aids include a manufacturer's equipment warranty that includes parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. This warranty must be provided at no cost to the beneficiary or to Medicaid. Manufacturers may not charge for packing, shipping, invoicing, postage, insurance, or handling while the hearing aid is under warranty.

Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. The manufacturer is also responsible for all shipping costs on non-warranty equipment repairs.

4.10 Hearing Aid Fitting and Checking Services

Follow-up hearing aid fitting and checking services performed by a hearing aid dealer or audiologist are covered services after the hearing aid's 90-day dispensing fee period. Hearing aid fitting and checking visits may include, but are not limited to, all the following services: device inspection, maintenance and cleaning, reprogramming or setting of internal device controls, listening checks, device counseling/training/education, and physical fit adjustments. Individual services included in the fitting and

checking visit or device handling, pick up, and drop off fees are not to be charged separately. Hearing aid fitting and checking visits may be billed up to a maximum of two times per year without PA.

4.11 Replacement

Medicaid covers one (monaural) or two (binaural) hearing aids once every five years. PA is required when a hearing aid is needed more frequently.

If a hearing aid is lost or damaged beyond repair within five years of the dispensing date and the 12-month loss and damage warranty has expired, Medicaid will pay for the replacement of the aid **one** time. Beneficiaries age 21 years and under may be eligible for additional replacements. PA is required.

Medicaid will not replace a hearing aid when lost or damaged beyond repair as a result of misuse or abuse by the beneficiary or caregiver. If loss or damage to a hearing aid is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the MSA-1653-B. All liable insurance coverage should be sought before requesting replacement by Medicaid.

4.12 Digital Hearing Aids

4.12.A. Standards of Coverage – Unilateral Hearing Loss

Age Under 21 Years	A digital **monaural** hearing aid is covered for beneficiaries with unilateral hearing loss documented by **one** of the following: ▪ An audiogram showing hearing loss of 25 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear. Normal hearing is defined as a Pure Tone Average (PTA) air-conduction hearing threshold of better than or equal to 20 dB HL; or ▪ Results of a complete diagnostic audiological evaluation (e.g. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	A digital **monaural** hearing aid is covered when **all** the following apply: ▪ Unilateral hearing loss documented by an audiogram showing a hearing loss of 30 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear. Normal hearing is defined as a PTA air-conduction hearing threshold of better than or equal to 20 dB HL; ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory indicates a need for amplification; and ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.B. Standards of Coverage – Bilateral Hearing Loss

Age Under 21 Years	A digital **monaural or binaural** hearing aid is covered for beneficiaries with bilateral hearing loss documented by one of the following: ▪ An audiogram showing a hearing loss of 25 dB HL or greater in both ears using the four-frequency average of 500, 1000, 2000 and 4000 Hz; or ▪ Results of a complete diagnostic audiological evaluation (e.g. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	A digital **monaural or binaural** hearing aid is covered when **all** the following apply: ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four-frequency average of 500, 1000, 2000, and 4000 Hz or the two-frequency average of 2000 and 4000 Hz; and ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.C. Prior Authorization Requirements

PA is not required for either monaural or binaural digital hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions, i.e., frequency of replacement, are not exceeded.

PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract
- Replacement aids within five years

All Ages	For beneficiaries of all ages, the following documentation must be submitted with the MSA-1653-B: ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory). ▪ A medical clearance signed and dated by the primary care or specialty provider within six months prior to prescribing the hearing aid. ▪ Recommended manufacturer, model, and style of hearing aid. ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges. ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system.

Age 21 Years or Over	In addition to the above documentation, providers must submit the following for beneficiaries 21 years or older: ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.D. Documentation

Applicable documentation to be maintained in the beneficiary record includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory);
- A medical clearance signed and dated by the primary care provider or otolaryngologist within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and
- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.

4.12.E. Payment Rules

Most items have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.13 Contralateral Routing Systems

4.13.A. Standards of Coverage

All Ages	A contralateral routing hearing aid is covered when **one** of the following applies: ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates thresholds less than or equal to 30 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz; or ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates a hearing loss greater than 25 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz.

Age 21 Years or Over	In addition to the above, beneficiaries age 21 years or over must have **all** the following: ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory that indicates a need for amplification; and ▪ A hearing loss that interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.B. Prior Authorization Requirements

PA is not required for monaural or binaural contralateral routing hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions (i.e., frequency of replacement) are not exceeded.

PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract.
- Replacement aids within five years.

All Ages	When PA is needed, the following documentation must be submitted with the MSA-1653-B: ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system's standards of coverage have been met (e.g., audiogram and amplification inventory); ▪ A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid; ▪ Hearing aid recommended manufacturer, model, and style; ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges; and ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.
Age 21 Years or Over	In addition to the above, providers must submit the following documentation for beneficiaries age 21 years or over: ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.C. Documentation

Applicable documentation to be maintained in the beneficiary record for a contralateral routing hearing aid includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system's standards of coverage have been met (i.e., audiogram and amplification inventory);
- A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer's invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and
- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system, including letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.

4.13.D. Payment Rules

Each of the HCPCS codes for contralateral routing systems covers both the transmitter and the receiver/hearing aid. Monaural codes should be used when providing one contralateral routing device to a beneficiary who already wears a Contralateral Routing of Signals (CROS) compatible hearing aid in the better ear. Providers should choose the procedure code that corresponds to the appropriate model being fit on the poorer ear. Binaural codes should be used when providing one hearing aid and one contralateral routing device. No other hearing aid device procedure code may be billed in addition to the specific contralateral routing systems code used.

Most devices have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or indicated on the MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.14 Non-Contract Hearing Aids

Hearing aid providers must provide hearing aids available through the MDHHS volume purchase contract whenever possible. If the provider prescribes a non-contract hearing aid, the hearing aid provider must obtain PA.

In addition to the required documents listed under the Digital Hearing Aids – Prior Authorization Requirements or the Contralateral Routing Systems - Prior Authorization Requirements subsections (as applicable) of this chapter, a letter of medical necessity must be submitted with the MSA-1653-B. The letter must identify the specific medical reason(s) why a contracted hearing aid will not meet the beneficiary's needs.

4.14.A. Payment Rules

Payment for a non-contract hearing aid may not exceed Medicaid's maximum allowable amount unless the documentation submitted with the MSA-1653-B supports the need for the more advanced technology found with a non-contract hearing aid. When documentation of the need for a non-contract hearing aid is provided, the payment is the acquisition cost for the non-contract hearing aid. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

Medicaid requires all non-contract hearing aids to include a manufacturer's equipment warranty that covers parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. The warranty is included in the hearing aid's acquisition cost and should not be charged separately.

SECTION 5 – HEARING AID SUPPLIES, ACCESSORIES, AND REPAIRS

5.1 STANDARDS OF COVERAGE

Hearing aid supplies and accessories are a covered benefit when medically necessary. A list of approved supplies, accessories, and maximums is available on the Hearing Aid Supplies and Accessories list located on the MDHHS website. (Refer to the Directory Appendix for website information.)

5.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for the following hearing aid supplies and accessories:

- Any single item billed with requested payment amounts over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- An item that exceeds the frequency standards of coverage.
- Items when the sum of all payments for supplies/accessories billed within the past year is over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- Battery charger or rechargeable battery.

A list of supplies/accessories provided within the past year and a copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges must be submitted with the MSA-1653-B.

5.3 DOCUMENTATION

Applicable documentation to be maintained by the provider includes:

- A list of hearing aid supplies/accessories provided to the beneficiary within the past year.
- A copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges.

5.4 PAYMENT RULES

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.5 DISPOSABLE HEARING AID BATTERIES

5.5.A. STANDARDS OF COVERAGE

Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 36 batteries per hearing aid per DOS when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of 72 batteries per aid per year is covered.

Disposable hearing aid batteries must be ordered by a Medicaid enrolled physician or qualified non-physician medical practitioner (e.g., physician assistant, nurse practitioner,

clinical nurse specialist). The dispensing supplier may require a written prescription from the prescribing provider. The prescription must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- Date the prescription was written;
- Description of the item prescribed, including the battery size;
- Quantity to be dispensed and number of applicable refills. Providers should note the item maximums when determining these amounts; and
- Diagnosis supporting the medical necessity of the item.

Prescriptions are valid for one year from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club," where batteries are automatically mailed to a beneficiary regardless of need, is not allowed. Hearing aid dealers and medical suppliers may not bill for replacement of disposable batteries for cochlear implant devices.

5.5.B. Prior Authorization Requirements

PA is required for quantities exceeding the standards of coverage. Documentation must accompany the MSA-1653-B to substantiate the need for additional batteries.

5.5.C. Payment Rules

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.6 Replacement Earmolds

Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds after the 90-day dispensing period. PA is not required when the earmold standards of coverage are met.

5.6.A. Standards of Coverage

Age 3 Years or Under	Up to four times per 12 months
Age 3 to 21 Years	Up to two times per 12 months
Age 21 Years or Over	Once every 12 months

5.6.B. Prior Authorization Requirements

PA is required for replacements exceeding the standards of coverage. Documentation must accompany the MSA-1653-B to substantiate the need for additional earmold replacements.

5.6.C. Payment Rules

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.7 Hearing Aid Repairs and Modifications

5.7.A. Standards of Coverage

Providers may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. MDHHS volume purchase contract vendors must continue to honor the repair pricing of the contract under which the hearing aid was sold for the life of the hearing aid. The vendor is responsible for all shipping costs related to warranty and non-warranty equipment repairs. When a warranty covered hearing aid requires a repair by the manufacturer, MDHHS will not reimburse the hearing aid dealer/audiologist for hearing aid fitting/checking services.

Repairs are not covered for back-up aids or devices.

The replacement of a hearing aid will be considered when the cost of the equipment repair is greater than the replacement. When submitting a PA request for the replacement, the provider must provide a statement regarding the cost to repair the aid/device versus replacement.

5.7.B. Prior Authorization Requirements

PA **is** required for repairs and modifications to out-of-warranty hearing aids if any of the following apply:

- The requested payment amount is over the maximum payment limit as published on the MDHHS Hearing Aid Dealers Fee Schedule. (Refer to the Directory Appendix for website information.)
- More than two separate repairs or modifications have been billed within the previous year.
- The hearing aid was not purchased under the MDHHS volume purchase contract.

Documentation must be submitted with the MSA-1653-B. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of $0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing. A repair processing fee of $19.20 per

aid may be added to the repair cost for hearing aids that are not covered under any warranty.

The repair or modification of a hearing aid not purchased by Medicaid may be covered only when all the following apply:

- The beneficiary's hearing level, as supported by an audiogram, meets Medicaid coverage criteria; and
- The aid itself meets Medicaid coverage criteria.

The MSA-1653-B for this type of repair or modification must include the date of purchase, warranty expiration date, and the current audiogram.

5.7.C. Documentation

Applicable documentation to be maintained in the beneficiary's record includes an itemization of materials used to repair the hearing aid and related labor costs.

5.7.D. Payment Rules

Medicaid's payment for hearing aid repairs or modifications includes no more than the actual repair cost plus a $19.20 processing fee per aid. Actual repair cost consists of acquisition cost of materials used for the repair, related labor costs, and shipping costs. The $19.20 processing fee may only be added to repairs that are not covered under a warranty. The maximum payment limit is published on the MDHHS Hearing Aid Dealers Fee Schedule.

Non-warranty repair pricing for hearing aids purchased under the MDHHS volume purchase contract are fixed rates established by the contract under which the hearing aid was sold. These rates apply for the life of the hearing aid.

SECTION 6 – OTHER HEARING DEVICES

6.1 ASSISTIVE LISTENING DEVICES

An Assistive Listening Device (ALD) is defined as a special purpose electro-acoustic device designed to enhance receptive communication (e.g., Pocket Talker).

6.1.A. STANDARDS OF COVERAGE

All Ages	ALDs are a benefit for beneficiaries when all the following conditions are met: ▪ Patient management of a personal hearing aid is considered unrealistic and/or frequency specific audiometric data cannot be obtained in each ear; ▪ The beneficiary has not received a Medicaid covered ALD within the last three years; ▪ The ALD is provided for situations involving one-on-one conversation.

6.1.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all ALDs.

All Ages	The following documentation must be submitted with the MSA-1653-B: ▪ A manufacturer's invoice showing the item acquisition cost; ▪ A letter or other supporting medical documentation from the audiologist demonstrating why a personal hearing aid is inappropriate and the recommended type of ALD; ▪ An audiogram signed and dated by the audiologist within six months prior to dispensing the device, or documentation showing that frequency-specific audiometric data could not be obtained in each ear within six months prior to dispensing the device.

6.1.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes all the following:

- A letter or other supporting medical documentation from the audiologist demonstrating why a personal hearing aid is inappropriate and the recommended type of ALD;
- An audiogram signed and dated by the audiologist within six months prior to dispensing the device, or documentation showing that frequency-specific audiometric data could not be obtained in each ear; and
- A copy of the manufacturer's invoice showing the ALD model, serial number, invoice price, applicable discounts, and shipping charges.

6.1.D. Payment Rules

Medicaid's payment for an ALD includes the provider's acquisition cost plus a percentage over cost. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs. Medicaid does not reimburse providers for a separate dispensing fee for ALDs.

6.2 Cochlear Implants

Cochlear implants are devices that replace the function of the cochlear structures and provide electrical energy to auditory nerve fibers. They require a surgically placed internal device and external hardware. The surgery must be performed by a licensed medical doctor (MD) or doctor of osteopathy (DO) who specializes in otolaryngology and has training and expertise in the surgical procedure.

Cochlear implantation may be an option to improve communication skills for adults with a moderate to profound hearing loss and for children with a severe to profound hearing loss who receive limited or no benefit from hearing aids.

6.2.A. Standards of Coverage

Unilateral and bilateral cochlear implantation is covered with PA for beneficiaries meeting the standards of coverage and audiological criteria. Implants must be FDA approved and used according to FDA labeled indications. Cochlear implants are covered for pre- or post-lingual deafness.

Hearing aids, hearing aid services, and accessories may be covered after the beneficiary has received a unilateral cochlear implant with PA. Documentation must be submitted to support improvement in speech perception abilities using a hearing aid in the opposite ear. Documentation of hearing aid audibility measures (i.e., speech mapping) on prescriptive hearing aid measurements may be submitted for beneficiaries who are unable to participate in speech perception testing.

All Ages	In addition to meeting the cochlear implant audiological criteria, **all** the following requirements must be met for unilateral and bilateral implantation: ▪ A letter from the treating otolaryngologist establishing medical necessity and recommending implantation. ▪ For beneficiaries with bilateral sensorineural hearing loss, a minimum of a three-month trial of an appropriately-fitted hearing aid(s). The trial period may be waived or shortened with appropriate documentation of medical necessity. ▪ For beneficiaries with single sided deafness/unilateral hearing loss or asymmetric hearing loss, a minimum of a one-month trial of appropriately-fitted CROS hearing aid or another suitable hearing device. The trial period may be waived with appropriate documentation of medical necessity. ▪ Evidence of a functioning auditory nerve. ▪ An accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This may be demonstrated by an appropriate radiological evaluation.

	▪ Freedom from middle ear infection or any other active disease. ▪ No medical or behavioral health contraindications for anesthesia or surgery. ▪ Cognitive ability to use auditory cues. ▪ Psychological development, motivation of the beneficiary, and/or commitment of the beneficiary and family/caregiver(s) to undergo a program of prosthetic fitting, training, and long-term rehabilitation. ▪ Realistic expectations of beneficiary and/or family/caregiver(s) for post-implant educational/vocational rehabilitation, as appropriate. ▪ Reasonable anticipation by treating providers that the cochlear implant(s) will confer awareness of speech at conversational levels. ▪ Documented intervention or school placement, as appropriate. Documentation may include the Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) involving individuals with specialization in the education of children who are deaf or hard of hearing.

6.2.A.1. AUDIOLOGICAL CRITERIA

Bilateral Sensorineural Hearing Loss **Under Age 18 Years**	• Diagnosis of bilateral severe to profound sensorineural hearing loss defined as pure tone average (PTA) equal to or greater than 70 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz (ANSI 1989) in an unaided condition. For children under 24 months, electrophysiological assessment must corroborate behavioral testing. • Lack of auditory skills development or minimal hearing aid benefit documented by one of the following: ➢ Results or outcomes of parent questionnaire (i.e., Infant Toddler-Meaningful Auditory Integration Scale [IT-MAIS]). ➢ Word recognition scores equal to or less than 60 percent under the best aided condition or score appropriate for model to be implanted, on open set tests (i.e., Multisyllabic Lexical Neighborhood Test or Lexical Neighborhood Test. ➢ Other age-appropriate developmental tests.
Bilateral Sensorineural Hearing Loss **Age 18 Years and Older**	▪ Diagnosis of bilateral moderate to profound sensorineural hearing loss defined as a PTA equal to or greater than 40 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz in an unaided condition. ▪ Minimal hearing aid benefit documented by a score of equal to or less than 50 percent under best-aided conditions or score appropriate for model to be implanted, on an open-set sentence recognition test (i.e., Hearing in Noise Test [HINT] Sentences or AzBio Sentences).

Single Sided Deafness/Unilateral Hearing Loss **Age 5 Years and Older**	▪ Diagnosis of severe to profound sensorineural hearing loss in the ear to be implanted defined as a PTA equal to or greater than 80 dB HL or level appropriate for model to be implanted, averaged over 500-4000 Hz. ▪ In the contralateral ear, normal or near normal hearing as defined as a PTA equal to or better than or 30 dB HL averaged over 500-4000 Hz. ▪ For beneficiaries age 18 years and older, limited hearing aid benefit from an appropriately fitted unilateral hearing device documented as a score of less than or equal to 5 percent on a Consonant Nucleus Consonant (CNC) word test. ▪ For beneficiaries under age 18 years, insufficient functional access to sound in the ear to be implanted documented by an aided speech perception test score of 5 percent or less on developmentally appropriate monosyllabic word lists when tested in the ear to be implanted alone.
Asymmetric Hearing Loss **Age 5 Years and Older**	▪ Diagnosis of profound sensorineural hearing loss in the ear to be implanted defined as a PTA equal to greater than 90 dB HL averaged over 500-4000 Hz in one ear ▪ In the contralateral ear, mild to moderately severe sensorineural hearing loss defined as a PTA of equal to or up to 55 dB HL averaged over 500-4000 Hz. ▪ Hearing loss difference of at least 15 dB in PTA between ears. ▪ For beneficiaries age 18 years and older, limited hearing aid benefit from an appropriately fitted unilateral hearing device documented as a score of less than or equal to 5 percent on a Consonant Nucleus Consonant (CNC) word test. ▪ For beneficiaries under age 18 years, insufficient functional access to sound in the ear to be implanted documented by an aided speech perception test score of 5 percent or less on developmentally appropriate monosyllabic word lists when tested in the ear to be implanted alone.

6.2.B. PRIOR AUTHORIZATION

Unilateral and bilateral cochlear implantation require PA. All audiological evaluations must be signed and dated by the audiologist and performed within one year of the date of the PA request unless otherwise specified.

All Ages	The following documentation must be submitted with the MSA-1653-B: ▪ Documentation of complete audiologic evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage (as defined above) applicable to the beneficiary have been met. ▪ A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations. ▪ Documentation of appropriately fitted hearing aids (for the trial period) verified through prescriptive measurements (e.g., aided audiograms). ▪ Documentation of minimal or no benefit from appropriate amplification (e.g., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with appropriately submitted medical documentation. ▪ Documentation of an accessible cochlear lumen structurally suited to implantation (e.g., no evidence of lesions in the auditory nerve and acoustic areas of the central nervous system). This must be demonstrated by an appropriate radiological evaluation. ▪ Identification of the cochlear manufacturer of the internal device, with the model of the external processor. ▪ Identification of the anticipated side to be implanted (unilateral only).
Age 12 Months Through 17 Years	In addition to the documentation for beneficiaries of all ages, the following must also be submitted for beneficiaries aged 12 months through 17 years: ▪ Speech and language evaluation report; and ▪ Documented intervention or school placement, as appropriate. Documentation may include the IFSP or IEP involving individuals with specialization in the education of children who are deaf or hard of hearing.

6.2.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes:

- Complete audiologic evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage applicable to the beneficiary have been met.
- A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations.
- Documentation of appropriately fitted hearing aids verified through prescriptive measurements (e.g., aided audiograms).
- Aided speech perception test battery results.

- Documentation of minimal or no benefit from appropriate amplification (i.e., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with medical documentation.
- Documentation of an accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This must be demonstrated by an appropriate radiological evaluation.
- Identification of the cochlear manufacturer of the internal device and model of the external processor.
- Identification of the anticipated side to be implanted (unilateral only).

6.2.D. Programming/Mapping

Cochlear implant mapping is the programming of the speech processor to the specifications and needs of its user following cochlear implant surgery. Mapping is used to analyze sound and convert the speech information into electrical impulses to the implanted electrodes. An initial post-operative session may be billed once per beneficiary per implant. Subsequent programming/mapping sessions may be billed up to five per year per implant. If additional sessions are needed, PA is required.

6.2.E. Repairs, Accessories, and Replacement Parts Standards of Coverage

Cochlear implant repairs, accessories, replacement parts, internal implants, and external speech processors may be covered when dispensed by a cochlear implant manufacturer and the applicable standards of coverage have been met. Charges should reflect no more than the usual and customary (U&C) charge to the general public.

Replacement of the internal cochlear implant device is covered with PA in cases when the audiologist or physician (e.g., otolaryngologist) indicates the function of the internal device has failed and is no longer under warranty. A letter from the manufacturer corroborating the internal device failure is required.

Replacement of the cochlear implant external speech processor with a new same generation or new upgraded speech processor is covered with PA when documentation from the licensed audiologist or physician substantiates the need for the replacement processor. Payment for the speech processor includes an initial supply of batteries.

Internal Cochlear Implant or Speech Processor Repair or Replacement	Internal cochlear implant devices and external speech processors may be repaired or replaced when all the following apply: ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA approved. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost.

	For replacement of a speech processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.
Accessories and Replacement Parts	Accessories and replacement parts may be covered when all the following apply: ▪ The accessory or replacement part is no longer covered by the manufacturer's warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a cochlear implant device that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved cochlear implant device.

6.2.F. Repairs, Accessories, and Replacement Parts Prior Authorization Requirements

PA is required for the following repairs, accessories, and replacement parts:

- External sound processors;
- Cochlear repairs, accessories, or implant parts when the sum of all charges exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Cochlear repairs, accessories, or implant parts when the sum of all charges within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule; and
- Items exceeding the frequency maximums published on the MDHHS Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the MDHHS Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	When PA is required, the following documentation must be submitted with the MSA-1653-B: ▪ Documentation from the licensed audiologist or physician, signed and dated within the previous six months, that substantiates the need for the part(s) and/or repair; and ▪ Manufacturer's invoice itemizing the materials used to repair the device and the rationale for any related labor costs.

6.2.G. Replacement Parts and Accessories List

A list of approved cochlear implant replacement parts and accessories is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.2.H. Non-Covered Items

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.

6.3 Bone Anchored Hearing Devices

Some beneficiaries may have physical or medical conditions that prevent them from wearing traditional hearing aids. A BAHD is an alternative hearing instrument for those who can benefit when there is no other suitable aid.

6.3.A. Implantable

A BAHD or aid, also known as an auditory osseointegrated device, is an implantable bone-conduction hearing aid that allows direct bone-conduction of sound through an implant. The device has both implanted and external components. The implanted component is attached to the skull bone behind the ear. The external component is a speech processor connected to an implanted abutment or internal magnet. The surgically implanted components and initial external speech processor are covered as a bundled procedure at the hospital benefit level.

All device repairs and replacements, including the processor and batteries, are covered as specified on the MDHHS Hearing Services Fee Schedule.

6.3.B. Non-Implantable

BAHD sound processors can also be used without surgery when they are attached to the head by a headband device or adhesive adapter placed behind the ear. A headband system is the option for beneficiaries who meet the BAHD audiological criteria but are not appropriate surgical candidates and need hearing assistance via bone conduction.

6.3.C. Standards of Coverage

Unilateral and bilateral implantable and non-implantable BAHDs are covered for beneficiaries meeting the standards of coverage and audiological criteria. An air conduction hearing aid must also be contraindicated, failed, or not appropriate for the beneficiary's medical condition. Conditions not meeting these criteria are considered investigational/experimental and are not covered. Beneficiaries must be five years of age or older for surgically implanted BAHDs.

All Ages	▪ Has documented unilateral or bilateral conductive or mixed hearing loss or unilateral profound sensorineural hearing loss as defined under BAHD audiological criteria. ▪ Use of an FDA-approved device in accordance with its labeled indications. ▪ Has at least one of the following conditions: ➢ Congenital malformation(s) of the middle/external ear or microtia; ➢ Severe chronic otitis externa and/or chronic suppurative otitis media with chronic drainage preventing use of conventional air conduction hearing aids; ➢ Conductive hearing loss due to ossicular disease and is not appropriate for surgical correction; ➢ Tumors of the external ear canal and/or tympanic cavity; ➢ Unilateral sensorineural hearing loss (single-sided deafness); or ➢ Condition that contraindicates an air conduction hearing aid.

6.3.C.1. AUDIOLOGICAL CRITERIA [CHANGE MADE 7/1/2025]

Unilateral or Bilateral Conductive or Mixed Hearing Loss	▪ PTA bone conduction threshold less than or equal to 65 dB HL or level appropriate for model to be implanted using the four-frequency average of 500, 1000, 2000 and 4000 Hz in ear to be implanted. ▪ **(text deleted per bulletin MMP 25-03)**
Unilateral Sensorineural Hearing Loss	▪ Confirmed profound hearing loss (greater than or equal to 90 dB HL using the four-frequency average of 500, 1000, 2000 and 4000 Hz) in one ear, with normal hearing (defined as a PTA air-conduction hearing threshold of better than or equal to 20 dB HL) on the contralateral side.
Bilateral Implantation or Devices	▪ Bilateral symmetrical conductive or mixed hearing loss with a PTA bone conduction threshold less than or equal to 65 dB HL, or level appropriate for model to be implanted, in each ear using the four-frequency average of 500, 1000, 2000 and 4000 Hz; and ▪ Bone conduction threshold of less than or equal to 15 dB HL average difference between ears.

6.3.D. PRIOR AUTHORIZATION

Bilateral device implantation or dispensing requires PA.

All Ages	The following documentation, dated within six months prior to the surgical implantation or dispensing of the device, must be submitted with the MSA-1653-B: ▪ Complete audiology report (i.e., pure-tone audiogram) that defines the type and degree of hearing loss in each ear. ▪ History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid. ▪ Letter from treating otolaryngologist stating medical need.

6.3.E. Documentation

Applicable documentation to be maintained in the beneficiary's record includes:

- Complete audiology report (e.g., pure-tone audiogram) that defines the type and degree of hearing loss in each ear.
- History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid.
- Letter from treating otolaryngologist stating medical need.

6.3.F. Repairs, Accessories, and Replacement Parts Standards of Coverage

Replacement of the internal implanted BAHD or external sound processor is covered in cases when the audiologist or physician (i.e., otolaryngologist) indicates the function of the device has failed and is no longer under warranty. Documentation from the licensed audiologist or physician to substantiate the need for the replacement must be submitted with the MSA-1653-B. Payment for the sound processor includes an initial supply of batteries.

BAHD accessories, replacement parts, and repairs may be covered when dispensed by a cochlear implant manufacturer and applicable standards of coverage have been met. All charges for BAHD accessories, replacement parts, and repairs are to reflect no more than the usual and customary (U&C) charge to the general public.

Implant or Sound Processor Repair or Replacement	Implants and external sound processors may be repaired or replaced when all the following apply: ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA-approved. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost. For replacement of a sound processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.
Accessories and Replacement Parts	Accessories and replacement parts may be covered when all the following apply: ▪ The accessory or replacement part is no longer covered by the manufacturer's warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a BAHD that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved BAHD.

6.3.G. Repairs, Accessories, and Replacement Parts Prior Authorization Requirements

Replacement of a BAHD external sound processor is not covered more frequently than once every four years. Replacements are not covered during the warranty period.

PA **is** required for the following repairs, accessories, or replacement parts:

- Bilateral external sound processors;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Items exceeding the frequency maximums indicated on the Bone Anchored Hearing Device Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the Bone Anchored Hearing Device Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	The following documentation, dated within six months prior to the dispensing of the part or repair, must be submitted with the MSA-1653-B: ▪ Documentation from the licensed audiologist and/or other medical professional to substantiate the need for the part(s) and/or repair. ▪ Manufacturer's invoice itemizing the materials used to repair the device and the rationale for any related labor costs.

6.3.H. Replacement Part Maximums

A list of approved BAHD replacement parts and maximums is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.3.I. Non-Covered Items

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.

HOME AND COMMUNITY BASED SERVICES

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SECTION 1 – GENERAL INFORMATION

1.1 OVERVIEW

On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released the Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), some 1915(b)(3) and 1115 authorities of the Social Security Act. These requirements, as further specified in this chapter, aim to improve the quality of the lives of individuals, allowing them to live and receive services in the least restrictive setting possible with full integration in the community. The Michigan Department of Health and Human Services (MDHHS) is responsible for ensuring all requirements are met.

The HCBS Final Rule includes the following:

- Requirements for the person-centered planning process to ensure individuals are involved in planning their services and supports to the maximum extent possible and that their wishes are reflected in the person-centered service plan.
- Requirements for HCBS and the settings in which they are provided. Settings in which individuals live (residential) and settings where individuals go to receive services (non-residential) are affected by the HCBS Final Rule. The settings requirements aim to ensure community integration and to ensure individuals receiving Medicaid HCBS have the same opportunities as individuals in those settings who are not receiving Medicaid HCBS.
- Allows CMS to approve or renew demonstration and waiver programs for five years if individuals are dually eligible for Medicare and Medicaid.
- Requires a 30-day public notice and comment period, including at least one non-electronic form of communication, for:
  - Substantive changes, including but not limited to, revisions to services available under the waiver including: elimination or reduction of services, or reduction in the scope, amount, and duration of any service; a change in the qualifications of service providers; changes in rate methodology; or a constriction in the eligible population; and
  - Any significant proposed change in its methods and standards for setting payment rates for services in accordance with federal law.
- Allows states to combine target groups based on diagnosis, disability, Medicaid eligibility groups, and/or age under one waiver authority.
- Provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process. Telemedicine is an acceptable method of assessment. Federal statute requires the State to provide for an independent assessment of need to establish a person-centered service plan. The assessment must be conducted at least every 12 months, or as requested by the individual or their representative, and/or as needed when there is a significant change in the individual's services or support needs. The individual's person-centered service plan must be updated to reflect this change in needs. For more information, refer to the federal regulation.

- Clarifies the scope of the term "individual representative." An individual representative may be:
  - The individual's legal guardian or other person authorized by state law to represent the individual in decision-making related to the individual's care or well-being. CMS offers that, in instances where state law gives decision-making authority to an individual representative, the individual receiving services will lead the person-centered planning process where possible and the individual representative will participate as needed and desired by the individual receiving services;
  - Any other person authorized under federal law or state policy to represent the individual, including but not limited to a parent, family member, or other advocate; and
  - If the representative is authorized by the state, the state must have policies in place that describe the authorization process, the extent of the decision-making authority, and safeguards to ensure the representative is acting on behalf of the individual with exceptions in cases where the individual's wishes cannot be determined or if the individual's wishes would be harmful.

1.2 Effective Date

The HCBS Final Rule was effective March 17, 2014. With the exception of the Home and Community Based (HCB) settings requirements, all topics covered by the HCBS Final Rule were effective on this date. The HCBS Final Rule requires programs approved by CMS after March 17, 2014, to be in immediate compliance with the entire HCBS Final Rule, including the settings requirements. The MI Health Link HCBS Waiver was initially approved by CMS for January 1, 2015, and must be in immediate compliance with the HCBS Final Rule.

Programs in existence before March 17, 2014 must be compliant with the federal HCB Settings Requirement on or before March 17, 2022:

- MI Choice Waiver
- Habilitation Supports Waiver
- Children's Waiver Program
- Children with Serious Emotional Disturbance Waiver Program
- Managed Specialty Services and Supports Waiver Program

Providers should refer to the relevant program chapter in this manual for requirements unique to that program.

SECTION 2 – PERSON-CENTERED PLANNING

The HCBS Final Rule provides guidance regarding the person-centered planning process. The HCBS Final Rule requires the individual to direct the process and lead it to the extent possible and desired by the individual, with participation of people chosen by the individual and to the extent desired by the individual. The individual's representative, if applicable, should have a participatory role as needed and defined by the individual unless decision-making authority has been granted to the representative by State law. The person-centered planning process must:

- Occur in a timely manner and at times and locations of the individual's choosing;
- Provide information and support to the individual in order to ensure maximum direction from the individual and to enable informed choice;
- Provide an informed choice of supports and identify who provides them;
- Include a mechanism to request updates in the plan;
- Document alternative(s) considered but not chosen;
- Include strategies for resolving disputes and identifying conflicts of interest; and
- Be free from conflict of interest, meaning those persons who have an interest in or are employed by a provider of HCBS for the individual must not be involved in case management or development of the person-centered service plan, except when the State demonstrates that the entity is the only willing and qualified entity available to complete these functions and also provide HCBS.

The person-centered service plan must be in written format and signed by the individual and their representative, as applicable, and providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports). The person-centered service plan must be distributed to the individual and any others involved in the plan. The plan must be reviewed at least every 12 months, or more frequently if the individual chooses or has a change in service needs.

The person-centered service plan must:

- Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need;
- Include what is important to the individual regarding their preferences for the delivery of the services and supports;
- Reflect that the individual has chosen the setting in which they reside, also including non-disability specific settings;
- Reflect the individual's strengths and preferences;
- Reflect the clinical and support needs as identified through an assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect services and supports that will assist the individual to achieve the identified goals, and identify the providers of those services and supports;

- Reflect risk factors and measures in place to minimize them, including backup plans and strategies;
- Identify the person or entity responsible for monitoring the plan;
- Be finalized and agreed to with the informed consent of the individual;
- Include self-directed services;
- Prevent the provision of unnecessary or inappropriate services and supports;
- Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan:
  - Identify the specific assessed need(s);
  - Document the positive interventions and supports used previously;
  - Document less intrusive methods that were tried and did not work, including how and why they did not work;
  - Include a clear description of the condition that is directly proportionate to the assessed need;
  - Include regular collection and review of data to measure the effectiveness of the modification;
  - Include established time limits for periodic review of the modification;
  - Include informed consent of the individual; and
  - Include assurances that the modifications will cause no harm to the individual.

The person-centered service plan must be written in plain language that is easily understood by the individual and others supporting them. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.

SECTION 3 – HOME AND COMMUNITY BASED SETTINGS

3.1 CHARACTERISTICS OF A HOME AND COMMUNITY BASED SETTING

Through the HCBS Final Rule, CMS imposed certain requirements for HCB settings which consist of those settings where individuals live (residential settings) and those where individuals go to receive services (non-residential settings). All HCB settings where people live or receive Medicaid HCBS must have the following characteristics to the same extent as those individuals not receiving Medicaid HCBS:

- Be integrated in, and support full access to, the greater community, including opportunities to seek competitive and integrated employment, control of personal resources, and access to community services;
- Be selected by the individual from among a variety of setting options and, for residential settings, consistent with the individual's available resources to pay for room and board;
- Ensure individuals have the right to privacy, dignity and respect, as well as freedom from coercion and restraint;
- Optimize but not regiment the individual's autonomy and independence in making life choices regarding what they participate in and with whom; and
- Facilitate the individual's choice of services and supports, as well as who provides them.

When an individual chooses to receive Medicaid HCBS in a provider-owned and/or -controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle. Any home owned or leased by a provider must adhere to the additional requirements described in federal law.

Settings that are presumed to not meet the HCB settings requirements are:

- Those in a publicly- or privately-owned facility providing inpatient treatment;
- On the grounds of, or adjacent to, a public institution; or
- Any that otherwise have the effects of isolating individuals from the broader community of individuals who are not receiving Medicaid HCBS.

Settings that are on the grounds of, or adjacent to, a private institution are not automatically presumed to have the characteristics of an institution. However, if the setting isolates the individual from the broader community (or otherwise has the characteristics of an institution) or fails to meet the characteristics of an HCB setting, the setting would **not** be considered to be compliant with the regulation.

All settings, including facility- or site-based settings (e.g. pre-vocational services in a facility-based setting such as a sheltered workshop or dementia-specific adult day care centers) must demonstrate the qualities of HCB settings, ensure the individual's experience is HCB and not institutional in nature, and does not isolate the individual from the broader community. In particular, if the setting is designed specifically for people with disabilities, or individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them, the setting may be isolating unless the setting facilitates and encourages people going out into the broader community.

3.1.A. Requirements for Residential Settings

The requirements for residential settings apply to provider-owned or controlled settings. An individual's private home is presumed to be compliant with the HCB requirements. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances in all living arrangements as those not receiving Medicaid HCBS.

3.1.A.1. Meals

Individuals must have access to food at any time. This does not mean the residential setting must be prepared to make a full meal at any time, but the individual must have access to some type of food when they choose. The type of food offered must be something that the individual likes to eat.

3.1.A.2. Visitors

Individuals must be allowed to have visitors of their choosing at any time.

3.1.A.3. Lockable Doors

Residential settings must have bedroom and bathroom doors that are lockable by the individual, with only appropriate staff having keys to the doors. The doors must be lockable from the inside of the room and equipped with positive-latching, non-locking-against-egress hardware. This means the door should open from the inside in one single motion such as the turn of the knob or handle. If a setting has private bedrooms that include private bathrooms, only the main door to the bedroom/unit must be lockable, though MDHHS encourages that both the bedroom door and bathroom door be lockable.

3.1.A.4. Freedom to Furnish and Decorate Room

Individuals must have the freedom to furnish and decorate their room however they choose. In the case of a shared room, the furnishings and decor may be a collaborative effort with roommates.

3.1.A.5. Choice of Roommate

Individuals must have their choice of roommate if possible. In some circumstances, there may only be limited beds available at the residence so if the individual chooses that setting, they may also be choosing that bed without the ability to choose the roommate. Different arrangements may be made as the individual continues to live in that setting.

3.1.A.6. Freedom to Control Schedule, Activities and Resources

Individuals must have freedom to control their own schedules, activities and resources to the extent they desire. If they choose to receive assistance, that should be provided as needed and desired by the individual.

3.1.A.7. Privacy

Individuals must have privacy in their unit. This includes physical privacy as well as keeping any of the individual's confidential information private. Protected health information and other confidential personal information must not be kept in an open, common, unlocked area.

3.1.A.8. Accessibility

Each setting must be physically accessible to the individuals residing there so the individuals may function as independently as they wish. Individuals must be able to move around in the setting without physical barriers getting in their way. This is especially true for individuals utilizing wheelchairs or who require walking aids. Furniture must be placed in such a way that individuals can easily move around it, with pathways large enough for a wheelchair, scooter or walking aids to navigate easily if individuals with these types of mobility aids reside in the setting.

3.1.A.9. Evictions and Appeals

Individuals receiving services must have a lease or other legally enforceable agreement that offers comparable responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other locality.

For settings in which landlord/tenant laws do not apply, MDHHS or its designee must ensure that a lease or other written agreement is in place for each individual and that the lease or agreement provides protections that address eviction processes and appeals similar to that of landlord/tenant laws.

3.1.A.10. House Rules

Although house rules are optional under State of Michigan licensing rules for Adult Foster Care and Homes for the Aged, for the purposes of the HCBS Final Rule, house rules will not be permitted.

3.1.A.11. Control of Personal Resources

The HCBS Final Rule requires that individuals be able to control their personal resources.

3.1.B. Requirements for Non-Residential Settings

The requirements of non-residential settings apply to provider-owned or -controlled settings. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances as others receiving the same service.

3.1.B.1. Skill-Building Assistance

Skill-building assistance must provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual. This service assists individuals in increasing their self-sufficiency or to develop the skills needed to engage in meaningful community-based activities such as school, work or volunteer activities.

3.1.B.2. Community Living Supports

Community Living Supports (CLS) must promote community inclusion and participation and facilitate an individual's independence and productivity. Services should provide opportunities for integration with the community and participation in activities comparable to activities for individuals of similar age or with similar interests who do not receive Medicaid HCBS.

3.1.B.3. Supported Employment

Supported employment provides a combination of ongoing support and paid employment that enables the individual to work in the community. Setting options offered should include community-based, integrated work settings where individuals with disabilities work alongside other individuals who do not have disabilities.

3.1.B.4. Adult Day Care

Adult day care programs must offer activities for individuals receiving Medicaid HCBS that are comparable to those tasks and activities for individuals of similar age and ability who are not receiving Medicaid HCBS. There also must be interaction between individuals receiving Medicaid HCBS and those not receiving Medicaid HCBS. Services must provide an opportunity for integration with the larger community. Individuals must not be kept from moving around inside or outside of the non-residential setting. If individuals require supervision to move about the setting or go outside, that supervision must be provided.

3.2 Settings Not Compliant with the HCBS Final Rule Requirements

Some settings have been identified by CMS as not HCB due to institutional status and will never be considered HCB. These settings are:

- Nursing facilities
- Institutions for mental disease
- Intermediate care facilities for individuals with intellectual disabilities
- Hospitals
- Other locations that have characteristics of an institution (e.g., Child Caring Institutions)

3.3 Reverse Integration

According to the HCBS Final Rule, reverse integration does not make a setting HCB. Reverse integration is when the setting brings providers into the setting from the community instead of taking the individual out to the provider. For example, medical providers, members of clergy, hairstylists, or nail artists, among others, are brought into the setting. While it is acceptable to have providers such as these come into the setting, this must not be the only contact with community providers allowed for individuals receiving services. Individuals must also have the option to go out into the community and participate with providers of their choosing.

3.4 Remediation of Settings and Relocation of Individuals

Based on review by MDHHS, some residential and non-residential settings that are not institutions may be considered to be non-compliant with the HCBS Final Rule due to not meeting the characteristics of an HCB setting as defined by CMS. The State and its contracted entities will work with these settings to bring them into compliance if the setting owner chooses to be compliant. If the setting owner declines to come into compliance with the HCBS Final Rule, the State and its contracted entities will work with affected individuals to transition to a different setting that is compliant. As applicable, individuals must be provided with compliant residential or non-residential options from which to choose. If the individual does not want to move to a different, compliant setting, they will be disenrolled from the Medicaid HCBS program.

Timeframes for relocation of individuals and continued program participation are dependent on the aforementioned CMS requirements for whether the specific program is considered new or existing as of the effective date of the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.

3.5 Heightened Scrutiny

The State and CMS have a process for "heightened scrutiny" which consists of further review of any settings that wish to participate and are considered compliant with the HCBS Final Rule with all characteristics except some, such as location of the setting close or connected to an institution. This will involve MDHHS and its contracted entities gathering evidence of potential compliance and submitting this to CMS for final approval.

MDHHS is responsible for determining if a setting qualifies for the "heightened scrutiny" process through its assessments of the setting that appears to have qualities which are HCB and does not have qualities that are institutional in nature. MDHHS will request that this type of setting go through the "heightened scrutiny" process with CMS. Only a setting that can comply 100 percent with the federal HCB Settings Requirement will be submitted to CMS for "heightened scrutiny" process.

A setting that will require heightened scrutiny has at least one of the following characteristics:

- Settings located in a building that is also a publicly- or privately-operated facility that provides inpatient institutional treatment.
- Settings in a building on the grounds of, or immediately adjacent to, a public institution.
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.

3.6 New Settings

All new settings (either newly established or new to the specific program) must be immediately compliant with the HCBS Final Rule. Determination of a new setting's compliance with the HCBS Final Rule must be determined after the setting is built and has been operational with residents or individuals receiving services in order for the evaluating entity to have a full understanding of the individual's experience while participating with the setting.

3.7 New Providers

Effective October 1, 2017, any new HCBS provider and their provider network must be in immediate compliance with the federal HCBS Final Rule in order to render services to Medicaid beneficiaries. This requirement does not apply to existing providers and their provider networks who rendered HCBS to Medicaid beneficiaries before the effective date of this requirement. The Michigan Department of Health and Human Services (MDHHS) will continue to work with existing providers towards coming into compliance with the federal HCBS Final Rule as specified in the State Transition Plan.

In order to comply with the federal HCBS Final Rule, new providers must:

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Enhance independence;
- Enhance independence in making life choices;
- Enable choice regarding services and who provides them; and
- Ensure that the setting is integrated in, and supports full access to, the greater community.

New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the:

- Setting is selected by the individual from among setting options;
- Individual has a lease or other legally enforceable agreement providing similar protection;
- Individual has privacy in their unit, including lockable doors;
- Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit;
- Individual controls their own schedule, including access to food at any time;
- Individual can have visitors at any time; and
- Setting is physically accessible.

New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting:

- Does not isolate the individual from the broader community; and
- Is not institutional in nature or has the characteristics of an institution.

3.8 Ongoing Monitoring

The State and its contracted entities are responsible for conducting ongoing monitoring activities to ensure settings remain in compliance with the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.

HOME HEALTH

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers.

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in any setting in which normal life activities take place. 'Normal life activities' refers to activities that could occur in or out of an individual's home. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care, physical therapy and/or home health aide services rather than personal care or physician's care.

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, physical therapy (PT), occupational therapy (OT), speech therapy (ST) and care by home health aides. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation (42 CFR § 484) and the policies outlined in this manual.

Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP) or Integrated Care Organization (ICO), the HHA must contact that health plan for authorization to provide services to their members.

Medicaid home health services must be ordered, in writing, by the beneficiary's physician (MD, DO, DPM) as part of a written plan of care (POC). The POC must be reviewed by the physician or permitted non-physician practitioner (NPP) every 60 days, acting within the scope of their current medical practice and Medicaid guidelines.

Permitted NPPs include:

- A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with State law.
- A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician.

Ordering/referring, certifying, and attending physician for home health is defined as a physician with a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Podiatric Medicine (DPM). Physicians must act within the scope of their current medical practice and Medicaid guidelines.

This chapter includes information about services covered for Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries unless otherwise noted.

Private Duty Nursing (PDN) is not covered under the Home Health benefit.

1.1 Face-to-Face Encounter

The physician or permitted non-physician practitioner (NPP) certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90-days prior to or 30-days after the start of care. The face-to-face encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act.

NOTE: The face-to-face encounter requirement pertains only to initial certification for home health services.

The face-to-face encounter ensures that the orders and certification for home health services are based on current knowledge of the beneficiary's clinical condition, and will identify the primary reason for home health services.

In a situation where a physician or permitted NPP orders home health services based on a new condition that was not evident during a visit within the 90-days prior to the start of care, the certifying practitioner (e.g. physician or permitted NPP) must see the beneficiary within 30 days of admission to home health services.

The certifying practitioner must document the face-to-face encounter. When the face-to-face encounter is performed by a certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State Law), they must document the clinical findings of the face-to-face encounter and communicate those findings to the physician; the physician must then sign the certification. Permitted NPPs must not certify face-to-face encounters performed by a certified nurse-midwife.

Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include:

- Date of the encounter,
- Primary reason for the encounter (medical condition),
- Clinical findings that support the need for skilled nursing, therapy, or home health aide services, and
- Clinical findings that support home health eligibility.

An addendum may consist of clinical documents from a hospital or post-acute facility (e.g., emergency visit record or discharge summary). It is allowable for the certifying practitioner to use such a document as an addendum for the face-to-face encounter if:

- The addendum contains all the documentation requirements for face-to-face documentation; and
- The certifying practitioner signs and dates the addendum; or
- The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the certified nurse-midwife who performed the face-to-face encounter, and that the certifying physician is using the addendum document as their documentation of the face-to-face encounter.

While typically the same practitioner (e.g. physician or permitted NPP) will certify, establish and sign the POC, it is allowable for practitioners who attend to the beneficiary in the acute and post-acute settings to

certify the need for home health care based on their face-to-face contact, initiate the orders (POC) for home health services, and "hand off" the beneficiary's care to the community-based practitioner to review and sign off on the plan of care.

1.2 Electronic Visit Verification

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. HHCS provided through Home Health must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

SECTION 2 – SERVICE SETTING

Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally restricted to their home but may be provided, as appropriate, in any setting in which normal life activities take place. A determination and documentation are required by the HHA to validate the beneficiary's eligibility and need for home health services. Home health services are **not** provided solely on the basis of convenience.

All covered home health services may be rendered in a beneficiary's home or any setting in which normal life activities take place, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child).

- Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or AFC facility as this would be duplication of personal care services already provided by staff of these facilities.
- Michigan Department of Health and Human Services (MDHHS) does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Intermediate Care Facility for the Mentally Ill (ICF/MI), school, adult day care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

To determine if home health services, rather than outpatient services, are most appropriate, consider the following:

- Are home health services necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics?
- Are home health services necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional?
- Is leaving the home medically contraindicated, as identified and documented by a health care professional?
- Are home health services necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional?
- Are home health services the most cost-effective method to provide care?

Services must be appropriate and medically necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, particular medical needs, and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.

SECTION 3 – PLAN OF CARE

The plan of care (POC) must include the mandatory elements required under Medicare CoP regulations at 42 CFR §484.60. The Medicare CoP POC elements represent the minimum information that must be included in each home health beneficiary's POC.

MDHHS requires home health providers must also include the following:

- Date of the first visit the HHA made for the new admission.
- Start date of care when the HHA began providing home care and the certification period. (This date remains the same on subsequent POCs until the beneficiary is discharged from home health care services.)
- Other identified resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help services, MI Choice Waiver).
- Name and address of the HHA, and the beneficiary's name, date of birth, and Medicaid ID number.
- The attending physician's or NPP's signature and date of signature. The POC must be signed and dated by the beneficiary's attending physician or NPP before the HHA submits a claim to MDHHS for payment.
- Specific circumstances, conditions, or situations that require services to be provided in the home and not in a physician's office or outpatient clinic.

If there is an order for Home Health aide services and the beneficiary is also receiving personal care through another entity (Home Help Program, MI Choice Waiver), there must be a coordination between the two entities and documentation in the POC to verify there is no duplication of services. (Refer to the Personal Care Section of this chapter for additional information.)

- Date of most recent hospitalization, if applicable.

If Home Health aide services are ordered, an assessment of the family's ability and willingness to perform the services must be made and included in the POC. If the family is unable to perform the services, the reason must be stated on the POC.

- Role of family or support person.
- Any additional items the home health agency, physician, or NPP chooses to include.

If the attending physician or NPP signs the POC after the service(s) is rendered, there must be a pre-existing written or verbal order for the service(s) to be covered by Medicaid. If the service(s) is rendered prior to the date the physician or NPP dated the POC and there is no pre-existing written or verbal order, Medicaid does not cover the service(s) provided. The verbal order obtained from the ordering physician must contain the signature of the HHA staff person who obtained the verbal order and the date the

verbal order was received. All verbal orders must be countersigned and dated by the ordering physician before the claim is submitted to MDHHS for payment.

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. The authorization and subsequent provision of home health services will continue to be based on medical necessity, not the setting. Any increase in the frequency of services, addition of new services, or modifications of treatment during a certification period must be authorized by the attending physician or NPP and documented in the beneficiary's medical record by way of a verbal order or written order prior to the provision of the increased, additional, or modified treatment.

The POC signed by the attending physician or NPP, along with any written or verbal orders as needed, and progress notes must be retained in the beneficiary's medical record.

SECTION 4 – TRANSFERS AND DISCHARGE PLANNING

The HHA must develop a transfer or discharge plan at the time of admission to home health services. As identified in the Medicare CoP (42 CFR §484.50), the beneficiary shall be discharged from the Home Health program by the admitting HHA under the following conditions:

- The beneficiary acuity exceeds the HHA's capabilities;
- The beneficiary or payer will no longer pay for home health services;
- The beneficiary no longer meets the criteria for medical necessity because the measurable outcomes and goals identified in the POC have been achieved;
- The beneficiary refuses services or elects to be transferred or discharged; OR
- The HHA provider cannot safely service the beneficiary in accordance with 42 CFR §484.50(d)(5).

It is the responsibility of the HHA to ensure continuity of care during transition or discharge to another HHA or entity (e.g., Home Help, MI Choice Waiver). The HHA's strategies for a safe transition or discharge must be documented in the beneficiary's medical record. The beneficiary's medical record must also identify the HHA or other entity from which the transition or discharge occurred.

In some cases, the beneficiary may receive home health aide services and start receiving services concurrently from other entities (e.g., Home Help, MI Choice Waiver). In such instances, the HHA must document in the medical record other resources used by the beneficiary in the POC.

SECTION 5 – COORDINATION OF SERVICES

The HHA must ensure coordination in the delivery of services through an integrated process across all aspects of home health services. Integrated services encompass communication from all physicians and disciplines (e.g., skilled nursing and therapy services) as well as other entities (e.g., Home Help, MI Choice Waiver). The HHA must also provide ongoing training and education for the beneficiary and caregiver with respect to the care and services identified in the POC, as well as for the safe transfer into or discharge from the community services.

Throughout the care planning process, it is the responsibility of the HHA to ensure coordination of care and to avoid duplication of services (e.g., Home Help. MI Choice Waiver).

SECTION 6 – OUTCOME AND ASSESSMENT INFORMATION SET

The Centers for Medicare & Medicaid Services (CMS) requires Medicare certified HHAs to use a standard assessment data set, referred to as the Outcome and Assessment Information Set (OASIS). The requirement to collect and submit OASIS clinical data applies to all beneficiaries receiving Medicare and/or Medicaid home health services. This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, ICO, Children's Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitation Supports Waiver, Healthy Michigan Plan, and CSHCS who receive home health services are to have OASIS information collected by the HHA. Assessments for all beneficiaries are to be conducted in compliance with Medicare certification requirements.

The OASIS requirements do not apply if the HHA is providing only housekeeping/ chore services, prepartum and postpartum services, or if the beneficiary is under 18 years of age.

HHAs are also required to electronically transmit the OASIS data to the designated state agency responsible for collecting OASIS data in accordance with CMS specifications. MDHHS contracts with a vendor to provide OASIS transmission assistance. HHAs needing assistance with transmitting data to the state repository should contact the MDHHS contractor. (Refer to the Directory Appendix for contact information.)

The CMS rules for OASIS are published in the Federal Registers that are available online at the OASIS website. (Refer to the Directory Appendix for website information.)

SECTION 7 – POST-PAYMENT REVIEW

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. All home health services ordered are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services provided, as well as the type of provider and setting, were appropriate, necessary, and compliant with Medicaid policy. Post-payment review also includes verification that appropriate procedure codes were used to bill the services provided.

Post-payment review includes verification that all third-party resources were utilized to their fullest extent prior to billing MDHHS. If post-payment review reveals that MDHHS was billed prior to utilizing these resources and the HHA knew the beneficiary had other insurance coverage for the service rendered, it may be considered fraud.

The General Information for Providers Chapter of this manual contains additional information regarding post-payment review and fraud.

SECTION 8 – NURSING SERVICES

Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

A nursing visit may include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered.
- Changing an indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, available family member, willing friend or neighbor, or caregiver (paid or unpaid) to carry out all or some of the services, as detailed below.
- Observation and evaluation, as detailed below.

Intermittent (separated intervals of time) nurse visits are intended for beneficiaries who generally require nursing services on a short-term basis (typically 60 days or less) for the treatment of an acute illness, injury, or disability and who cannot receive these services in an outpatient setting. Intermittent nursing visits may last from 15 minutes to one or two hours and are reimbursed at a flat rate (i.e., Medicaid fee screen for a visit) regardless of the length of the visit.

Intermittent nurse visits are not covered for a beneficiary receiving Private Duty Nursing Services.

Intensive care (for cases that require five or more visits per week or beyond 60 days) may be reviewed by MDHHS during post-payment audit to determine if home care was medically appropriate and a cost effective alternative to institutional care.

Nursing services must be provided through the State Plan Medicaid program in accordance with established policy. MI Choice nursing services shall not duplicate services available through the Medicaid State Plan home health benefit, and under no circumstance shall the beneficiary receive both MI Choice and State Plan services concurrently. Waiver agencies cannot authorize payment for services that are (already) offered under the State Plan.

8.1 COVERED NURSING SERVICES

The following nursing services are covered home health care services. Limitations, conditions and special considerations are noted when applicable. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for billing information.)

8.1.A. BLADDER TRAINING

When use of a catheter is temporary, visits made by the nurse to change the catheter must also include instruction to the beneficiary in bladder training methods. The actual bladder training (e.g., forcing fluids or other measures) does not require the skills of a nurse. After the catheter is removed, a limited number of visits (maximum two visits per month) are allowed to observe and evaluate the effectiveness with which the bladder training has been accomplished (e.g., the degree to which the bladder is emptying).

8.1.B. Enemas

Giving enemas usually does not require the skills of a nurse, and Medicaid does not cover such visits unless the physician or NPP has ordered that a nurse give the enema because of clinical indications.

8.1.C. Eye Drops and Topical Ointments

Two nurse visits are allowed to teach the administration of eye drops and topical ointments. Nurse visits solely to perform these services are not covered.

8.1.D. Intravenous Infusions

If the beneficiary is in need of intravenous infusion and an infusion clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or family member/care giver will not accept this task, the HHA may perform this service and bill accordingly. Medicaid will reimburse claims for professional services (e.g., nursing services) associated with the administration of Medicare Part D drug(s) to dually eligible Medicaid/Medicare beneficiaries.

8.1.E. Neonatal Jaundice

Nurse visits related to neonatal jaundice require supporting documentation in the beneficiary's medical record that the nurse visits are required for a specific medical condition. Supporting documentation should include pertinent laboratory values.

8.1.F. Observation/Evaluation

If the attending physician or NPP determines that the beneficiary's condition is unstable and that significant changes may occur, Medicaid covers nurse visits for observation/evaluation. Once the beneficiary's condition has stabilized and there has been no significant change (e.g., no change in medication or vital signs, no recent exacerbation in the beneficiary's condition) for a period of three weeks, and no other necessary nursing services are being furnished, nursing visits solely for observation/evaluation are no longer covered.

Visits for observation/evaluation to ensure stability of a beneficiary who has an established disability or frail condition are covered by Medicaid if circumstances, conditions, or situations exist that prevent the beneficiary from obtaining services from a physician's office or outpatient clinic as described in the Home Setting Section of this chapter. Such visits are limited to two visits per month.

Nurse visits for observation/evaluation to ensure stability of a beneficiary's condition cannot be billed within a 30-day period of an initial/subsequent postpartum/newborn follow-up nurse visit, suspected abuse nurse visit or aide visit.

If the beneficiary is enrolled in the MI Choice Waiver, a nurse visit for observation and evaluation to ensure stability is not a home health covered service but a responsibility of the waiver staff. (Refer to the Directory Appendix for the website containing the regional map and addresses of the MI Choice Waiver agents.)

8.1.G. Oral Medications

Administration of oral medications does not usually require the skills of a nurse in the home setting. Visits are covered only if the complexity of the beneficiary's condition and/or the number of drugs prescribed require the skill or judgment of a nurse to detect and evaluate side effects (adverse reactions) and/or provide necessary teaching and instruction.

Placing medication in envelopes/cups, giving reminders, etc., to assist the beneficiary in remembering to take them does not constitute a nursing service.

8.1.H. Postpartum/Newborn Follow-up Nurse Visit

Home visits for assessment, evaluation and teaching are covered for women and newborns following delivery when a physician or NPP has determined the mother or newborn may be at risk. The goals of these services include:

- Fostering a positive outcome for the mother and newborn by detecting medical complications manifested during the postpartum/newborn period;
- Instructing the mother in newborn care; and
- Identifying situations that may require intervention with medical and community resources.

The HHA must assess and document, in writing, that the beneficiary is receiving services by a Maternal Infant Health Program (MIHP) provider. If the HHA is also an enrolled MIHP provider, services for the mother and newborn cannot be billed as home health care but must be billed as MIHP services. If the beneficiary is receiving MIHP services from another provider and the HHA is also providing services, the POC must clearly identify why home health services are needed in addition to MIHP and that the two providers do not duplicate services.

Medicaid allows one initial postpartum visit, one initial newborn visit, and one subsequent visit to mother and newborn for a total of three visits per pregnancy.

- The initial postpartum visit must be billed using the mother's Medicaid ID number.
- The initial newborn visit must be billed using the newborn's Medicaid ID number.
- The subsequent visit may be billed under either the mother's ID number or newborn's ID number, based on the most time spent with each beneficiary.

8.1.I. Prenatal Nurse Visit

Medicaid covers home visits for a specific pregnancy related medical condition provided by a HHA.

Home visits provided for preventive health services which address psychosocial issues, provide education, provide transportation, etc. and that do not provide treatment for an illness or injury are a covered service of the MIHP, not Home Health.

8.1.J. Routine Prophylactic and Palliative Skin Care

The recognized stages of decubitus ulcers are classified as:

- Stage I - Inflammation or redness of the skin;
- Stage II - Superficial skin break with erythema of surrounding area;
- Stage III - Skin break with deep tissue involvement; and
- Stage IV - Skin break with deep tissue involvement with necrotic tissue present.

The existence of Stage III or IV decubiti or other widespread skin disorders may necessitate the skills of a nurse. The physician's or NPP's orders for treating the skin determine the need for this service.

The presence of Stage I or II decubiti, rash, or other relatively minor skin irritations do not indicate a need for nursing care unless ordered by a physician or NPP. Bathing the skin, applying creams, etc. are not covered nursing services.

8.1.K. Suspected Abuse/Neglect

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the HHA must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Once suspected abuse is reported, the local MDHHS office can request supplemental home health visits to complement the protective services from MDHHS. Medicaid covers up to two home health visits for this purpose. The HHA must document in the beneficiary's medical record the county and the name of the individual MDHHS staff member who approved the request.

Approved visits must be ordered by the attending physician or NPP and documented in the beneficiary's medical record.

A nursing visit for suspected abuse cannot be billed within 30 days of an aide visit, an observation/evaluation, or an established disability or frail condition visit.

8.1.L. Teaching and Training Activities

HHA services are not covered if the beneficiary has a willing, available, and competent designated caregiver (e.g., family member, friend, neighbor, Home Help provider) that can demonstrate the ability for the beneficiary and/or designated caregiver to provide appropriate care. Medicaid does cover HHA teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability.

If a beneficiary or available family member is mentally/physically able to be taught and utilize a particular procedure, and the nurse has completed the teaching but the beneficiary or available family member is subsequently noncompliant, a maximum of three additional teaching visits are allowed for reinforcement teaching. (Medicaid defines noncompliance as the failure or refusal to follow instructions related to improving or stabilizing a condition.)

Teaching visits are not covered if a beneficiary, family member, friend, or neighbor is not mentally or physically able to be taught and utilize a procedure or service as documented in the POC. In these cases, as well as when a caregiver could be taught but is not available or willing to be taught, aide visits (not nurse visits) may be covered to perform these services as long as other Medicaid coverage criteria are met.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection
- Prefilling insulin syringes
- Inserting/irrigating a catheter
- Administering eyedrops/topical ointments
- Caring for a colostomy or ileostomy
- Administering oxygen
- Preparing and following of a therapeutic diet
- Applying dressings to wounds that require prescription medications and aseptic techniques
- Bladder training
- Bowel training (e.g., bowel incontinency, constipation due to beneficiary's immobility)
- Performing activities of daily living (e.g., dressing, eating, personal hygiene) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has suffered a loss of function
- Aligning and positioning a bed-bound beneficiary
- Performing transfer activities (e.g., from bed to chair or wheelchair, wheelchair to bathtub)
- Ambulating by means of crutches, walker, cane, etc.

Medicaid reimbursement for teaching visits is based on whether the teaching provided in the home is a reinforcement of previous teaching or is initial instruction. If teaching constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training.

Visits made solely to remind or emphasize to the beneficiary, family member, friend, or neighbor the need to follow the instructions are not covered services. However, visits to supervise and evaluate the practical application of training require the skills of a nurse and are considered reasonable and necessary where the complexity of the service being taught indicates such visits are warranted (e.g., insulin injections or preparation of formula feedings for gastrectomy beneficiaries).

Whether the teaching is reinforcement or initial, the nurse must establish the goal(s) or intended outcome(s) for the beneficiary and a reasonable period of time to attain them and document these in the POC. The beneficiary must be encouraged to become independent of skilled services in their home whenever feasible.

Visits for teaching and training activities solely to ensure stability or solely to prevent an illness, injury, or disability are only covered for beneficiaries who have an established or frail condition or for women/newborns following delivery, as detailed in previous sections.

Except as detailed above, visits solely for teaching designed to prevent an illness, injury, or disability are not covered. Visits for teaching must be necessary for the treatment of a specific illness. For example, instruction in the importance of good nutritional habits, exercise regimens, and good hygiene are not covered services in the absence of a specific supporting diagnosis of illness, injury, or disability.

8.2 Noncovered Nursing Services

The following services are not covered as home health nursing services. As noted, they may be covered under another service.

8.2.A. Bathing

Bathing does not require the skills of a nurse and is not covered by the Medicaid home health benefit.

8.2.B. Prefilling Insulin Syringes

If the sole purpose of a nurse visit is to prefill insulin syringes, this service is not covered as a nursing visit.

This service is covered as an aide visit with a maximum of two visits per month. The Remarks section of the claim must state that the visit was for prefilling insulin syringes.

8.2.C. Psychiatric Nursing Visit

Nursing visits for the primary purpose of providing a psychiatric nursing service are not a Home Health benefit covered by Medicaid, but may be covered under another Medicaid

program. Examples of noncovered nurse visits include psychiatric evaluation, psychotherapy, administration of psychotropic drugs, assessment of beneficiary's adjustment to a psychotropic drug, venipuncture to obtain specimen for psychiatric medication review, and nurse visit to prefill medication cups/boxes, giving reminders, etc., to assist the beneficiary in remembering to take psychiatric medication.

8.2.D. Routine Foot Care

Medicaid does not cover nursing visits solely to provide routine foot care (e.g., removal of corns, calluses, trimming of nails). Nursing visits for the debridement of mycotic nails are not covered by the Medicaid home health benefit.

SECTION 9 – THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Medicaid covers home occupational therapy (OT) and physical therapy (PT) when medically necessary, reasonable, and necessary to help the beneficiary return to a previous functional level or to a functional level that is appropriate to a stable medical status. Under certain circumstances, home speech therapy (ST) is covered for children enrolled in Children's Special Health Care Services (CSHCS). Refer to the Therapy Services Chapter of this manual for additional information.

SECTION 10 – HOME HEALTH AIDES

Home health aide services may be rendered independently, and not contingent upon the need of skilled nursing or therapy services. Home health aide services are covered only when ordered by the attending physician or NPP and authorized according to Medicaid policy. A physician must do the initial order and initial prior authorization for home health aide services. Subsequent orders and prior authorizations for continuation of services, decrease in services, or increase in services, may be ordered by a physician or NPP. The services provided by the home health aide must be medically necessary. Medicaid would not cover home health aide services solely for personal care needs, or for the convenience of the beneficiary. The POC must clearly outline the duties to be performed by the home health aide.

The HHA must identify the availability of other caregiver(s) (e.g., family member or another caregiver). The availability of the caregiver(s) must be identified in the POC. When a caregiver is providing services that adequately meet the member's needs, it is not medically necessary for the HHA to provide services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

10.1 HOME HEALTH AIDE PRIOR AUTHORIZATION

Home health aide services for Medicaid beneficiaries must be authorized by the MDHHS Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary.

Prior authorization is required each time services are requested for:

- continuation of services beyond the initial 90 days;
- continuation of services beyond the end date of the current authorization period (renewal);
- an increase in services; or
- a decrease in services.

The first prior authorization must be ordered by a physician. Subsequent prior authorizations may be ordered by a physician or NPP. The continuation of services beyond the initial 90 days must be ordered by a physician. A renewal, an increase in services, or decrease in services may be ordered by a physician or NPP.

After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician or NPP orders home health aide services, the HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians or NPPs ordering home health aide services must determine that medical services are medically necessary and appropriate for each PA request.

In some cases, the beneficiary's attending physician or NPP may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review. (Refer to the Forms Appendix for a copy of MSA-181.) If approved, the notification letter will contain the PA number and approved authorization dates.

It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division.

If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

10.1.A. Documentation Requirements

The following documentation is required for all initial PA requests for home health aide services and must accompany the MSA-181:

- documentation of the face-to-face encounter;
- all components of the POC as identified in 42 CFR §484 and MDHHS policy;
- OASIS; and
- other documentation as requested by MDHHS.

The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided.

- For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review.
- If a beneficiary's condition changes during an authorization period warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide.

- To request an increase in hours, the following are required:
  - an updated MSA-181 indicating the increase in hours;
  - an updated and signed POC; and
  - documentation from the attending physician or NPP.
- To request a decrease in hours, the following are required:
  - an updated MSA-181 indicating the decrease in hours; and
  - an updated and signed POC.

PA and documentation requirements apply to all Medicaid beneficiaries.

10.1.B. Medical Necessity

Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g., the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation);
- New or changed prescription medications (e.g., newly prescribed medications within the last 30 days or changed dosage, frequency, or route of administration within the last 60 days, including but not limited to diagnosis such as diabetes or hypertension);
- Recent hospitalizations (must include the date and reason for the hospitalization);
- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility);
- Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or
- Complicating factors (e.g., presence of Stage III or IV decubiti).

The beneficiary's medical necessity must be clearly identified by the physician or NPP and documented in the POC. All PA requests will be considered on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

10.1.C. Beneficiary Eligibility

Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To ensure payment, the HHA must verify beneficiary eligibility monthly at a minimum.

10.1.D. Retroactive Prior Authorization

Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

10.2 Supervisory Visit

The supervisory visit of the home health aide must be completed every 14 days to provide a more reliable and frequent supervision schedule with documentation of the supervisory visit in the beneficiary's medical record. The HHA RN must assign a home health aide to each beneficiary. It is the responsibility of the RN or other appropriate skilled professional (e.g., physical therapist, [PT], occupational therapist [OT], speech therapist [ST]) to prepare written instructions for the beneficiary's care and to conduct home health aide supervisory visits every 14 days as follows:

- If the beneficiary is receiving skilled nursing services, the RN must complete the supervisory visit; OR
- If the beneficiary is receiving only therapy services, the supervisory visit must be completed by the appropriate skilled professional (e.g., PT, OT, ST).

In some cases, the beneficiary may not be receiving skilled nursing or therapy services. In such cases, the RN must complete the supervisory visit of the home health aide no less than every 60 days. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Each supervisory visit by the RN or other appropriate skilled professional must be documented in the beneficiary's medical record.

In accordance with 42 CFR §484.80, the HHA must ensure that the qualifications and training of the home health aide are sufficient to meet the individual needs of the beneficiary.

SECTION 11 – PERSONAL CARE

If there is an order for home health aide services and the beneficiary is also receiving personal care services through another entity (e.g., Home Help Program, MI Choice Waiver), there must be coordination between the two entities and documentation in the POC to verify that there is no duplication of services.

It is the responsibility of the HHA to identify other services the beneficiary may be receiving to ensure the services of the home health aide and personal care services through another entity (e.g., Home Help, MI Choice Waiver) and to assess the ability of the family or caregiver to perform personal care services. For beneficiaries enrolled with another entity (e.g., Home Help Program or MI Choice Waiver), the HHA must contact the adult services specialist or the waiver agent to ensure coordination and verify services are not duplicative in nature, nor occur simultaneously.

11.1 HOME HELP PROGRAM

The Home Help Program provides unskilled personal care services (i.e., assistance with ADL, IADL, and complex care tasks) to assist eligible beneficiaries with functional limitation(s) resulting from a medical or physical disability or cognitive impairment. The beneficiary's adult services worker at the local MDHHS office issues a provider-specific service authorization that includes the list of tasks the personal care provider is authorized to furnish to the client. (Refer to the Providers [Provider Payments] Section of the Home Help chapter for more information.) The Home Health POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress if ordered by the attending physician or NPP.

11.2 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED

Medicaid's Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) covers those services to aged and disabled individuals (age 18 and over) who, without the provision of waiver services, would require nursing facility care. Examples of services are chore, respite, and emergency response systems.

MI Choice beneficiaries are identified in the eligibility response with the Benefit Plan ID of MI Choice-MC. (Refer to the Beneficiary Eligibility chapter for additional information.)

SECTION 12 – DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES

Durable Medical Equipment (DME), certain medical supplies, orthotic and prosthetic appliances, shoe supplies, and oxygen (gas and equipment) are covered services for HHA beneficiaries when providing medically necessary skilled nursing or aide services. HHAs are required to provide medically necessary equipment and supplies either directly or through arrangement with DME providers. These items must be supplied and billed by a Medicaid enrolled medical supplier, orthotist, prosthetist, shoe supplier, or oxygen supplier, except as noted below. The beneficiary's attending physician (MD, DO, DPM) or NPP must order these items in writing. These providers may have to obtain PA for certain services, and the services provided must be in accordance with Medicaid policies.

MDHHS encourages the HHA to submit the beneficiary's POC to the medical supplier to help support the need for the item.

Routine medical supply items are included in the reimbursement for the HHA's nurse or aide visit. No separate reimbursement for such supplies is allowed. These supplies include, but are not limited to:

- Band-aids
- Enema kits (e.g., Fleet)
- Gloves (sterile, nonsterile), up to four pair
- Simple dressing (including 10 4x4's and one roll of tape)
- Skin cleansers - swabs or wipes (e.g., iodine, alcohol, Betadine)
- Sterile solutions (up to 30 ml.)
- Syringes and needles
- Thermometers
- Cotton swabs, balls
- Specimen cups
- Suture removal kits
- Gowns

If the treatment regimen requires quantities beyond those listed above for gloves, simple dressings, or sterile solutions, the HHA or the medical supplier may bill separately for the additional quantities. The need for additional supplies must be documented in the medical record. These are items that may be left in the beneficiary's home between visits where repeated applications are required, and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician or NPP as part of a written POC.

The MDHHS Home Health Database, available on the MDHHS website, contains a list of medical supply items that may be billed separately from the nurse or aide visit. If the quantity needed is beyond what is listed on the Home Health Database, the supplies must be billed by a DME/Medical Supplier. (Refer to the Directory Appendix for website information.) HHAs choosing to provide routine medical supplies beyond what is listed on the MDHHS Home Health Database and other medically necessary equipment

and medical supplies directly to beneficiaries receiving home health services must enroll with Medicaid as DME providers. (Refer to the General Information for Providers chapter and the Medical Supplier chapter for additional information.)

SECTION 13 – NONCOVERED SERVICES

The services listed below are **not** covered under the home health program.

13.1 HOME UTERINE ACTIVITY MONITOR

Home health services related to the use of a home uterine activity monitor (HUAM) are not separately reimbursable. Reimbursement is made on a per diem rate to a medical supplier approved by MDHHS to provide this service. All equipment, perinatal nursing services, technical services, and supplies necessary for the provision of the HUAM are included in the rate.

13.2 DRUGS AND BIOLOGICALS

The cost of drugs and biologicals are not HHA benefits but may be covered by Medicaid. For information on PA for certain prescribed drugs, contact the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

13.3 EVALUATION VISITS

Nursing or PT evaluation visits to assess the acceptance of the beneficiary by the HHA are not covered (e.g., adequacy of the environment for providing nursing care or PT in the home, ability and willingness of family members to meet the beneficiary's medical needs in the home setting, if the beneficiary meets Medicaid home health policy criteria). When the agency makes such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not covered as a visit because the beneficiary has not been accepted for care by the HHA.

If, however, during the course of this initial evaluation visit the beneficiary is accepted by the HHA for care, and is also furnished the first service as ordered under the physician's or NPP's POC, the visit becomes the first billable visit.

13.4 HOSPICE

MDHHS does not separately reimburse HHAs for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All HHA services related to the beneficiary's terminal illness are either arranged for (contractual agreement), or provided by, the hospice program.

13.5 MEDICAL SOCIAL SERVICES

Medical social services are not a Medicaid covered HHA service.

13.6 MISSED VISITS

Missed visits are not covered. If a beneficiary is not home when HHA staff arrives to provide a service, MDHHS does not reimburse the agency for the missed visit. The HHA may not charge the beneficiary for a missed visit unless it is the HHA's normal practice to charge everyone for missed visits. (The HHA must notify the beneficiary, in advance, that the beneficiary is required to pay for missed visits.)

13.7 Oxygen

The administration of oxygen is included in the cost of the nurse or aide visit and is not separately reimbursable.

Oxygen gas and equipment are Medicaid benefits when supplied and billed by an enrolled pharmacy, oxygen supplier, or medical supplier in accordance with Medicaid policy.

HOME HELP

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SECTION 1 – GENERAL INFORMATION

1.1 OVERVIEW

Michigan's Medicaid state plan personal care services are provided through the Home Help program in accordance with 42 CFR §440.167. The program is administered by the Michigan Department of Health and Human Services (MDHHS) and provides personal care services to eligible Medicaid beneficiaries who need hands-on assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The purpose of the Home Help program is to support client well-being, safety, and choice. Home Help services enable clients with functional limitation(s) resulting from a medical or physical disability or cognitive impairment to live safely in the most independent setting. Authorized personal care services are based upon a comprehensive assessment conducted by an MDHHS adult services worker (ASW) and reflect the client's goals and preferences identified through a person-centered planning process. The Home Help program is designed to meet the following goals:

- Encourage and support the client's right and responsibility to make informed choices.
- Ensure necessary supports are offered to help the client live independently and with dignity.
- Recognize and encourage the client's natural support system.
- Empower the client to manage their services, respecting the client's right to determine what services are necessary, when they are completed, and how they are performed.

1.2 COMMON TERMS

Below are common terms used throughout this chapter:

Adult Services Worker (ASW)	This individual is an MDHHS employee and provides case management services for the Home Help program.
Agency Caregiver	A direct care worker employed by the agency provider. This individual provides Home Help personal care services to the client.
Agency Employee	An employee of the agency provider who has access to information regarding the client for the purposes of billing, answering phone calls, or assisting with setting up services for the client.
Agency Owner(s)	Possesses 5% or greater direct or indirect ownership interest of the agency provider and/or a person with control interest.
Agency Provider	▪ A current Medicare certified home health agency; **OR** ▪ An approved agency with a federal Employer Identification Number (EIN) that directly employs all (but not less than two) agency caregivers, not including the owner, who are providing services through the Home Help program and regularly receiving paychecks from the agency each month; **OR** ▪ A Community Mental Health Services Program (CMHSP) that works with clients who use arrangements that support self-determination.

Agency Representative/ Resident Agent/Authorized Agency Representative	An individual who is authorized to act on behalf of the agency owner.
Board of Directors	A group of individuals elected or selected to act as representatives of the shareholders to establish corporate management-related policies and to make decisions on major company issues.
Client	A Medicaid beneficiary who is receiving personal care services through the Home Help program.
Individual Caregiver	A direct care worker employed directly by the client. This individual provides Home Help personal care services to the client.
Managing Employee	A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the institution, organization, or agency either under contract or through some other arrangement, whether or not the individual is a W-2 employee.
Unapproved Agency Provider	An agency provider that is enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) but has not been approved to provide Home Help services or is earning the individual caregiver rate due to not being in full compliance with Home Help policy.

SECTION 2 – SERVICES

Medicaid funds are available for Home Help services provided to clients who meet the requirements outlined in the Eligibility Section of this chapter. The client's ASW can authorize up to 179.9 hours of Home Help services per month. Additional time may be authorized with approval from the MDHHS Home Help Policy Section. (Refer to the Directory Appendix for contact information.)

Home Help services eligible for Medicaid funding are limited to:

- Hands-on assistance with ADLs, IADLs, and complex care tasks.
- Contribution to the maintenance costs of a service animal. (Refer to Adult Services Manual [ASM] 137 for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

2.1 ASSISTANCE WITH ADLS

Home Help services are available to clients who require hands-on assistance with one or more ADLs, including:

- **Bathing**: Shampooing and drying the hair and cleaning the body or parts of the body using a tub, shower, or sponge bath. May include getting a basin of water; managing faucets; and soaping, rinsing, and drying the body.
- **Dressing**: Putting on and taking off garments; fastening and unfastening garments and undergarments; and assisting with special devices like back or leg braces, elastic stockings or garments, and artificial limbs or splints.
- **Eating**: Using utensils and a cup or glass; getting food and drink to the mouth; cutting up and manipulating food on the plate; swallowing food and drink; and cleaning the face and hands after a meal.
- **Grooming**: Maintaining personal hygiene and a neat appearance. May include combing and brushing the hair; brushing and cleaning the teeth; shaving; and fingernail and toenail care.
- **Mobility**: Walking or moving around inside the living area; changing locations in a room; climbing the stairs; maneuvering around pets; and managing obstacles like uneven floors.
- **Toileting**: Getting on and off the toilet, commode, or bed pan; emptying the commode, bed pan, or urinal; managing clothing; wiping and cleaning the body after toileting; cleaning ostomy or catheter tubes/receptacles; and applying diapers and disposable pads. May also include catheter, ostomy, or bowel programs.
- **Transferring**: Moving from one sitting or lying position to another; moving from the bed or wheelchair to the sofa; coming to a standing position; or repositioning the body.

2.2 Assistance with IADLs

Clients eligible to receive assistance with at least one ADL may receive assistance with one or more IADLs, including:

- **Laundry**: Gaining access to machines; sorting laundry; manipulating soap containers; reaching into the machine for laundry; operating the machine controls; hanging laundry to dry; and folding and putting away laundry.
- **Light housework**: Sweeping, vacuuming and washing floors; washing kitchen counters and sinks; cleaning the bathroom; changing bed linens; taking out garbage; dusting; cleaning the stove top; and cleaning the refrigerator.
- **Meal preparation or clean-up**: Planning menus; washing, peeling, slicing, and mixing ingredients; opening packages and cans; lifting pots and pans; reheating food; cooking; safely operating the stove; setting the table; serving the meal; and washing, drying, and putting away dishes.
- **Shopping**: Compiling a list; managing a cart or basket; identifying items needed; transferring items to the home and putting them away; and phoning in and picking up prescriptions. Limited to brief, occasional trips in the local area to shop for food, medical necessities, and household items required specifically for the health and maintenance of the client.
- **Taking medication**: Taking prescribed or over-the-counter medications.

2.2.A. Maximum Allowable Hours for IADLs

There are monthly maximum hour limits on all IADLs except taking medication. The limits are as follows:

IADL	Maximum Hours per Month
Shopping	5
Light housework	6
Laundry	7
Meal preparation	25

2.2.B. Proration of IADLs

Time authorized for all IADLs except taking medication is prorated by one half in shared living arrangements with other adults unless it can be clearly documented that assistance with the client's authorized IADLs is solely for the benefit of the client. **NOTE**: Proration is not required in situations where others live in adjoined apartments or flats or in a separate home on shared property with no shared common living area.

2.3 Complex Care Tasks

Complex care tasks are performed for a client whose diagnosis or condition requires a higher level of care than what is provided in assistance with ADLs and IADLs. Complex care tasks may require special treatment and equipment. The provider may need specific instructions by a medical professional or the client.

Common complex care tasks include:

- **Bowel program**: Recommended by a medical professional to aid a client with having a bowel movement or to prevent chronic constipation complications. May be recommended for a client with paralysis, paraplegia, hemiplegia, or lesions or congenital anomalies of the intestinal tract. Assistance may include a combination of digital stimulation, manual removal of stool from the rectum, insertion of a suppository, or an enema. **NOTE**: A bowel program that requires greater than 60 minutes of hands-on assistance per day requires medical documentation from a physician or nurse practitioner verifying the bowel program is safe and meets the client's needs.
- **Catheters or leg bags**: A client needing assistance with urinary voiding due to bladder dysfunction may need assistance with insertion, emptying, and replacing of an indwelling (Foley) catheter, intermittent catheterization, or suprapubic catheter maintenance and emptying. Catheterization activities include cleaning, replacing, and switching between different types of urine drainage bags.
- **Colostomy care**: A client who has had a portion of their colon removed or requires their colon to be diverted, either permanently or temporarily, may have an opening in the abdominal wall (called a stoma) emptying the colon contents into a drainage appliance and bag. A client with a colostomy may need assistance with maintenance and cleaning of the stoma site, as well as maintenance, emptying, cleaning, and replacement of the appliance and bag.
- **Eating or feeding assistance**: A client may need assistance with a feeding tube or supplemental food bag. Assistance may include the following feeding methods: bolus, intermittent bolus by gravity bag or syringe, continuous drip by gravity or pump, or a combination of continuous drip and bolus feedings. Tasks may include preparing the formula, checking the placement of the feeding tube, and priming the tubing or pump.
- **Injections**: A client may need medication(s) to be delivered via subcutaneous or intramuscular injections as ordered by a physician or nurse practitioner. Assistance with this task may include preparing medication, cleaning the injection site, and administering the injection as ordered. Some medications require testing prior to injection, such as using a blood glucose monitor prior to injecting insulin.
- **Peritoneal dialysis**: A client may have an option to do in-home dialysis in place of hospitalization or treatment at a dialysis center. May include continuous ambulatory peritoneal dialysis (CAPD) performed by a machine or manually. Assistance may include setting up, initiation, and discontinuation of infusion, adjustments to infusion, and monitoring vital signs. May require time for maintenance and cleaning of the dialysis machine and equipment.
- **Range of motion exercises**: A client with limited or no mobility may require assistance with range of motion exercises to prevent stiffness and contractures and to improve flexibility and circulation in joints and extremities. **NOTE**: For requests greater than 60 minutes per day, documentation from a prescribing medical professional is needed to detail treatment and exercises.

- **Respiratory treatment**: A client with altered airway function may require the administration of oxygen, nebulizer, aerosol, or respiratory therapy, or the use of mechanical aids to facilitate lung inflation. Assistance may include the use of medical gases and administration apparatus; humidification, aerosol, medications, ventilator support, percussion and cough assist devices; and airway management.
- **Specialized skin care**: A client with limited or no mobility who is at risk for skin breakdown may require turning and repositioning of their body to prevent development of decubitus ulcers (also known as bed sores or pressure ulcers), the use of pressure-reducing devices, and the treatment of decubitus ulcers with pads, creams, or lotions.
- **Suctioning**: A client with a tracheostomy, altered airway function, or choking or aspiration risks may require oral or tracheal suctioning to keep their airway open and free of mucous. Oral suctioning involves removing mucous secretions and foreign material from the mouth and throat with the use of a Yankauer catheter. Tracheal suctioning involves clearing mucus from the tracheostomy tube. Assistance may also include maintenance and cleaning of the tracheostomy, dressings, and equipment.
- **Ventilator**: A client who needs mechanical ventilation to support their respiratory function may need assistance with putting on or removing the ventilator, adjustments to ventilator settings, managing ventilator humidification, and maintaining and cleaning the ventilator. Non-invasive ventilator support may include continuous positive airway pressure (CPAP) and bi-positive airway pressure (Bi-PAP).
- **Wound care**: A client with a pressure, surgical, or other wound(s) may need assistance with cleaning, dressing, packing, debridement, and irrigation of the wound(s) or assessment of the wound(s) for complications, such as infection or vascular compromise. Wound care is prescribed and monitored by a physician or nurse practitioner, usually on a weekly or monthly basis, but can be performed by a trained caregiver.

This is not an exhaustive list of complex care tasks eligible for payment. Specific tasks are determined through a comprehensive assessment. (Refer to the Eligibility [Comprehensive Assessment] Section in this chapter for more information.)

2.4 Home Help Services in the Workplace

Home Help services may be used to enable the client to be employed. Additional service hours are not authorized for this purpose. The client determines how to distribute the authorized service hours between the home and workplace. Home Help services in the workplace are limited to hands-on assistance with ADLs, IADLs, and complex care tasks and do not include other tasks that may need to be performed as part of the client's work duties.

2.5 Home Help Services for a Minor Child

Home Help services provided to a minor child must be a necessary supplement to usual parental care and justified by the high service needs of the family. High service needs are those that arise from a minor child's physical, medical, emotional, or mental impairment and require significantly higher levels of intervention than those required by a child of the same age without similar impairments.

When a responsible relative(s) is unable due to a medical condition to meet a minor child's care needs, or is unavailable due to employment, school, or other legitimate reason, the responsible relative(s) can hire

a provider to perform the ADLs, medication administration, and meal preparation required during their absence. (Refer to ASM 101 for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

A responsible relative cannot be the paid provider for a minor child. A responsible relative is defined as a client's spouse or the parent of an unmarried client under the age of 18.

Payments are only for time authorized to complete approved tasks and cannot include time for childcare, supervision, or monitoring.

SECTION 3 – NONCOVERED SERVICES

Noncovered services include, but are not limited to:

- Supervising, monitoring, reminding, guiding, teaching, or encouraging the client.
- Services provided for the benefit of people other than the client.
- Services a responsible relative is able and available to provide. A responsible relative is defined as a client's spouse or the parent of an unmarried client under the age of 18.
- Similar services provided by another resource at the same time (i.e., a duplication of services).
- Transportation other than authorized travel time for shopping and laundry.
- Money management, such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities.

SECTION 4 – SERVICE SETTING

4.1 ALLOWABLE SERVICE SETTINGS

Home Help services may be authorized for a client living in:

- Their own home or apartment, either alone or with roommates or relatives.
- The home of a family member.
- A room and board or CMHSP-supervised setting that does not meet the definition of an Adult Foster Care (AFC) or Home for the Aged (HFA) facility.

4.1.A. ROOM AND BOARD SETTING

A room and board setting is one where, in exchange for a fee, a person is provided with a place to live and meals. If the client's name is on the lease and the setting does not meet the definition of an AFC or HFA, Home Help services may be provided. The client is not eligible for assistance with meal preparation.

The following may provide Home Help services to a client residing in a room and board setting:

- A homeowner who is related to the client. A homeowner is defined as the person or entity that owns, leases, or rents the room and board setting. **NOTE**: A responsible relative cannot serve as the Home Help provider. A responsible relative is defined as a client's spouse or the parent of an unmarried client under the age of 18.
- A provider that is not affiliated with the homeowner or the room and board setting.

When the homeowner is **not** related to the client:

- The homeowner must not serve as the client's Home Help provider.
- The homeowner's employees and relatives must not serve as the client's Home Help provider(s).
- The homeowner must not benefit financially from the Home Help payment to the client's Home Help provider.
- The homeowner must not be legally affiliated with or otherwise connected to the client's Home Help provider.

4.1.B. CMHSP-SUPERVISED SETTING

Residents of a CMHSP-supervised setting who receive community mental health (CMH) services may also qualify for Home Help services if the setting does not meet the definition of an AFC or HFA. Home Help services cannot be provided by the person or agency provider that owns, rents, or leases the home. A client's assessed hours for IADLs other than taking medication must be reduced by 50 percent unless it can be clearly documented that IADLs for the client are completed separately from other adults in the home. The client's ASW will make this determination in consultation with the client and their representative as part of the person-centered planning process.

4.2 Temporary Residence Outside of Michigan

A client with active Medicaid may remain eligible for Home Help services in a temporary residence outside the state if there is evidence of intent to return to Michigan. Payment can be authorized only for those services required by the client in any living arrangement (permanent or temporary) and only to the provider(s) authorized to provide Home Help services prior to the client's temporary absence. The client must have a demonstrated need for continuity of care during the temporary absence and must confirm with the ASW that the provider(s) is rendering services in the temporary residence.

An in-person comprehensive assessment with the ASW in the client's home is required to authorize an increase in services or the continuation of services beyond the client's six-month review date. (Refer to the Eligibility [Comprehensive Assessment] Section in this chapter for more information.)

4.3 Prohibited Service Settings

Home Help services cannot be authorized for a client who is an inpatient or resident of a(n):

- Hospital,
- Nursing facility,
- Institution for mental disease,
- AFC facility as defined in the Adult Foster Care Facility Licensing Act, Public Act 218 of 1979 (MCL 400.701 et seq.),
- HFA as defined in the Public Health Code, Public Act 368 of 1978 (MCL 333.20106), or
- Correctional institution, such as a state or federal prison or local jail.

4.3.A. Date of Facility Admission

Providers are not eligible for payment for Home Help services provided on the day a client is admitted to a nursing facility, institution for mental diseases, AFC, HFA, or correctional institution. Payments for Home Help services provided on these days are subject to denial and recoupment.

Providers may be eligible for payment for Home Help services provided on the day a client is admitted to a hospital. Refer to the Provider Payments (Payment for Services Provided on the Client's Hospital Admission Date) subsection in this chapter for more information.

4.3.B. Date of Facility Discharge

Providers are eligible for payment for Home Help services provided on the day a client is discharged from any of the facilities listed above.

4.3.C. Reporting Facility Stays

The client or provider must report a facility stay to the client's ASW within ten business days of the date of discharge to ensure proper Home Help payment.

SECTION 5 – ELIGIBILITY

Home Help services are available to an individual who:

- Meets Medicaid eligibility requirements,
- Has a certified medical need for services,
- Is determined through a comprehensive assessment to have a need for services,
- Does not have a responsible relative who is able or available to assist with ADL, IADL, and complex care tasks, and
- Is not concurrently enrolled in the MI Choice waiver program, MI Health Link, or the Program of All-Inclusive Care for the Elderly (PACE).

All criteria must be met to establish eligibility for Home Help services. The individual must continue to meet these eligibility requirements on an ongoing basis to remain eligible for services.

5.1 MEDICAID ELIGIBILITY

An individual may be eligible for Home Help services under one of the following conditions:

- All requirements for Medicaid have been met.
- The individual is a Medicaid deductible beneficiary, and their Medicaid deductible obligation has been met. (Refer to ASM 105 and the Medicaid Deductible Beneficiaries [Spenddowns] Section in the Beneficiary Eligibility chapter of this manual for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

5.2 MEDICAL ELIGIBILITY

The client's medical need for Home Help services must be certified using the Medical Needs form (DHS-54A). (Refer to the Forms Appendix for a copy of the DHS-54A.) The DHS-54A must be signed and dated by an approved Medicaid provider enrolled in CHAMPS who holds one of the following professional licenses:

- Physician (MD or DO)
- Physician assistant
- Nurse practitioner
- Occupational therapist
- Physical therapist

A Veterans Health Administration (VHA) medical provider may complete a DHS-54A or a VA Form 10-10M.

The client or their representative is responsible for obtaining the medical certification of need, but it must be completed by one of the medical professionals listed above. The medical professional must enter their National Provider Identifier (NPI) number on the DHS-54A or VA Form 10-10M and indicate whether they are a Medicaid-enrolled provider.

The medical professional certifies the client's need for services is related to an existing medical condition, physical disability, or cognitive disability. The medical professional does not prescribe or authorize personal care services. Needed services are determined by the comprehensive assessment conducted by the ASW.

5.3 Comprehensive Assessment

An ASW determines the client's need for Home Help services during a comprehensive assessment. The ASW issues a Time and Task to communicate to the client and provider the services that are authorized. (Refer to the Providers [Provider Payments] Section of this chapter for more information.)

5.3.A. Initial Comprehensive Assessment

Prior to case opening, an applicant must participate in an in-person comprehensive assessment with an ASW in the applicant's home. The purpose of the comprehensive assessment is to determine the applicant's eligibility for Home Help services.

5.3.B. Six-Month Review

Every six months, the client's comprehensive assessment must be updated during an in-person review with the ASW in the client's home.

5.3.C. Requests for Service Changes

A client requesting an increase in Home Help services must participate in a comprehensive assessment update with the ASW before the increase can be authorized. The update may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the update must be conducted in person in the client's home.

5.3.D. Case Transfer to a New County

A client who moves to a new county must participate in an in-person comprehensive assessment with the ASW in the client's home before payment for Home Help services in the new county can be authorized.

5.3.E. Requests for Service Changes

A client who requests a change in Home Help services must participate in a new review and comprehensive assessment with the ASW before payment can be authorized. The review and comprehensive assessment may take place in person or by phone. If the client is non-verbal or requests an in-person visit, the review and comprehensive assessment must be conducted in person in the client's home.

5.4 Status of Responsible Relatives

A responsible relative is defined as a client's spouse or the parent of an unmarried client under the age of 18. Home Help services may only be authorized if a responsible relative is unable or unavailable to provide the services.

An **unable** responsible relative has disabilities of their own that prevent them from providing care. These disabilities must be documented and verified by a medical professional on a DHS-54A. (Refer to the Forms Appendix for a copy of the DHS-54A.)

An **unavailable** responsible relative is absent from the home for an extended period due to employment, school, or other legitimate reasons. The responsible relative must provide documentation – such as a work or school schedule – that verifies they are unavailable to provide care.

When a client and a responsible relative reside in the same home, the IADLs of shopping, laundry, and light housework may only be authorized if they must be completed during the time the responsible relative is unavailable. **Example**: A client's spouse works from 7:00 a.m. to 6:00 p.m., Monday through Friday. If the spouse is able and available to assist with shopping, laundry, and light housework outside their work schedule, these tasks will not be authorized for the client.

A client who is separated from their spouse must provide verification that they no longer reside in the same home. Verification may include a driver's license, rent receipt, or utility bill. The separated spouse cannot serve as the Home Help client's provider.

5.5 Coordination With Other Services

Enrollment in the Home Help program is permitted if the client is enrolled in one or more of the following programs. For information about concurrent enrollment requirements, refer to the sections of this manual listed in the chart below.

Program / Services	Reference
Habilitation Supports Waiver for Persons with Developmental Disabilities	Habilitation Supports Waiver for Persons with Developmental Disabilities (Waiver Supports and Services) Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter
Children's Waiver	Children's Waiver Community Living Support Services Appendix (Coverage Decisions Section) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter
Home Health	Personal Care (Home Help Program) Section of the Home Health chapter
Hospice	Hospice Services (Home Help/Personal Care) Section of the Hospice chapter
Medicaid Health Plans	General Information (Services Excluded from MHP Coverage but Covered by Medicaid) Section in the Medicaid Health Plans chapter

SECTION 6 – HOME HELP PROGRAM ENROLLMENT

Home Help program enrollment begins with one or more of the following contacts with a local MDHHS office:

- A referral received by phone, U.S. mail, fax, or in person. The referral source does not have to be the individual in need of services.
- The submission of a completed and signed Adult Services Application (DHS-390).
- The submission of a completed and signed Medical Needs form (DHS-54A).

(Refer to the Directory Appendix for local MDHHS office contact information and the Forms Appendix for copies of the DHS-54A and DHS-390.)

6.1 ELIGIBILITY DETERMINATION

When Home Help services are approved, MDHHS mails the client the Services Approval Notice (DHS-1210) and the client's Time and Task, which lists the client's authorized services. The client's Time and Task may be different from the provider's Time and Task due to client choice or provider availability. The client's Time and Task indicates the maximum authorized time based on the client's assessed need. With prior approval from the client's ASW, the provider authorization may exceed the provider's Time and Task but may not exceed the client's Time and Task.

When Home Help services are denied, MDHHS sends the Adequate Negative Action Notice (DHS-1212A) and the Request for Hearing form (DCH-0092) to the client through U.S. mail. The case denial is effective on the date the notice is mailed to the client. The client can submit the DCH-0092 to appeal the determination.

(Refer to the Appeals [Client Appeals] Section in this chapter and ASM items 110, 115, and 150 for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

SECTION 7 – DISENROLLMENT

Home Help services payments may be terminated, and the client's case closed, when the client:

- Fails to meet any of the eligibility requirements.
- Fails to participate in a six-month review. (Refer to the Eligibility [Comprehensive Assessment] Section of this chapter for more information.)
- Voluntarily disenrolls from the Home Help program.
- Receives services from another program that results in a duplication of services.

(Refer to ASM items 155 and 170 for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

SECTION 8 – PROVIDERS

Home Help services are provided by individual caregivers, agency providers and agency caregivers. (Refer to the General Information [Common Terms] Section in this chapter for more information.) The Home Help program supports the client in selecting and supervising the provider(s). The client is the employer of the individual caregiver and is responsible for selecting and overseeing the agency provider. The client has the right to terminate services with the provider at any time. All providers must meet minimum provider qualifications established by the Home Help program.

8.1 PROHIBITED PROVIDERS

Home Help services cannot be provided by a(n):

- Responsible relative. (Refer to the Eligibility [Status of Responsible Relatives] Section of this chapter for more information.)
- Minor (17 years of age or under).
- Financial management services vendor, such as a fiscal intermediary or fiscal/employer agent.
- Current Home Help client.
- Provider convicted of a crime(s) that excludes the provider from Medicaid participation. (Refer to the Denial of Enrollment, Termination and Suspension [Termination or Denial of Enrollment] Section in the General Information for Providers chapter of this manual for more information.) **NOTE**: A client may be able to hire an individual caregiver with an excludable offense using the Personal Choice and Acknowledgement of Provider Selection process outlined below. An excluded provider not eligible for this process may request enrollment or reinstatement as a Medicaid provider. (Refer to the Denial of Enrollment, Termination and Suspension [Enrollment and Reinstatement After Termination or Denial] Section in the General Information for Providers chapter of this manual for more information.)

8.1.A. PERSONAL CHOICE AND ACKNOWLEDGEMENT OF PROVIDER SELECTION

A client may hire an individual caregiver who has been convicted of a crime that is not a federally mandated exclusion. The client must document their choice by signing and dating the Personal Choice and Acknowledgement of Provider Selection form (MSA-119). The MSA-119 verifies the client received notification of the criminal offense(s) that prompted the exclusion and affirmed their selection of the individual caregiver to deliver Home Help services.

The client receives the MSA-119 from their ASW or local MDHHS office. (Refer to the Directory Appendix for contact information.) After the signed acknowledgement is received, processed, and recorded by MDHHS, the effective start date for the selected individual caregiver is the date the client signs the MSA-119. Payment will not be authorized prior to the signature date on the form.

The client may only use the MSA-119 to select an individual caregiver who meets the following criteria:

- Does not have a disqualifying conviction that is one of the four exclusions under 42 USC 1320a-7(a). (Refer to the Denial of Enrollment, Termination and Suspension [Termination or Denial of Enrollment] Section in the General Information for Providers chapter of this manual for more information.)
- Is not legally responsible for the client.
- Meets the caregiver qualifications outlined in this chapter.

The MSA-119 cannot be used to select an agency provider or agency caregiver.

A personal choice selection may be applied for the limited purpose of providing Home Help services to the specific client identified on the MSA-119. A personal choice selection must not be construed as approval, authorization, or permission to provide services to other clients. If an individual caregiver with an exclusion wishes to work for multiple clients, an MSA-119 must be signed by each client. The approved date of payment is based on the date the client signed the MSA-119.

Individual caregivers selected through the personal choice provisions of this section must be registered in CHAMPS and other systems (if applicable) for the purposes of monitoring, contacting, and generating payments; however, such individuals are prohibited from either being placed in the provider referral database or receiving referrals for additional clients through that process.

8.2 Caregiver Qualifications

Agency caregivers and individual caregivers must be:

- 18 years of age or older.
- Able to follow instructions and Home Help program procedures and perform the services required.
- Able to handle emergencies and know when to seek assistance from appropriate sources in the event of an emergency.
- In adequate health to perform the needed services.
- Dependable and able to meet job demands.
- Willing to participate in available training programs, as necessary.
- In compliance with provider enrollment requirements. (Refer to the Providers [Provider Enrollment] Section of this chapter for more information.)

Home Help payments may be terminated if the caregiver fails to meet any of the above criteria.

8.3 Agency Provider Qualifications

To qualify for payment at the agency provider rate, an entity must be approved by the MDHHS Home Help Policy Section and be one of the following:

- A current Medicare certified home health agency.
- An agency with a federal EIN that directly employs all – but not less than two – agency caregivers, not including the owner, who provide services through the Home Help program and regularly receive paychecks from the agency each month.
- A CMHSP that works with clients who use arrangements that support self-determination.

(Refer to the Providers [Agency Provider Approval Process] Section of this chapter for more information.)

8.4 Provider Enrollment

All Home Help providers must enroll in CHAMPS and undergo a criminal history screening. (Refer to the Provider Enrollment Section of the General Information for Providers chapter of this manual for more information.)

8.4.A. Individual Caregiver Enrollment

Individual caregivers must be enrolled in CHAMPS prior to working with clients.

8.4.B. Agency Provider Enrollment

Agency providers must be enrolled in CHAMPS prior to working with clients. Additionally, agency owners must ensure agency employees and agency caregivers are properly enrolled in CHAMPS.

8.4.B.1. Agency Caregiver and Agency Employee Enrollment

The agency owner(s) must ensure that:

- All agency caregivers are enrolled in CHAMPS as atypical individual providers and associated to the agency provider prior to providing Home Help services. The date of this association must not be earlier than the date the criminal history check was completed to protect client safety. **NOTE**: An agency owner who provides direct personal care services to clients must also enroll in CHAMPS as an atypical individual provider and associate to their agency.
- All agency employees are listed in the agency provider's CHAMPS enrollment in "Step 9: Provider Controlling Interest/Ownership Details" prior to accessing client information.

(Refer to the General Information [Common Terms] Section of this chapter to determine which agency personnel meet the definition of an agency caregiver and an agency employee.)

When a post-payment audit reveals that MDHHS paid for services provided by one or more agency caregivers or agency employees who were noncompliant with CHAMPS enrollment policy, MDHHS will recoup the overpayments from the agency provider.

8.4.B.2. Home Help Agency Caregiver Enrollment Authorization Form (MSA-204)

The agency caregiver has the sole authority to submit their CHAMPS enrollment application but can use the Home Help Agency Caregiver Enrollment Authorization form (MSA-204) to delegate this responsibility to their employing agency provider. The MSA-204 documents that the agency caregiver:

- Permits the agency provider to complete the CHAMPS enrollment application in the agency caregiver's absence.
- Has read, understands, and agrees to all Home Help terms and conditions.

The agency provider must not enroll the agency caregiver in CHAMPS before the agency caregiver has completed the MSA-204 and submitted it to the agency provider. To protect client safety, the agency caregiver must not provide Home Help services until their CHAMPS enrollment application has been approved and the agency caregiver has associated to the agency provider in CHAMPS. A failure to comply with these requirements may result in recoupment from the agency provider of payments for services the agency caregiver provides. (Refer to the Forms Appendix for a copy of the MSA-204.)

8.5 Agency Provider Approval Process

To apply to become an approved agency provider, a new agency must:

- Have a federal EIN and a Type 2 (Organization) National Provider Identifier (NPI).
- Register with the Michigan Department of Licensing and Regulatory Affairs (LARA) or the agency's local County Clerk office.
- Create a vendor account in the State of Michigan Statewide Integrated Governmental Management Application Vendor Self Service system (SIGMA VSS). (Refer to the Directory Appendix for more information.)
- Enroll in CHAMPS.
- Submit the following documents to the MDHHS Home Help Policy Section:
  - A copy of the county registration if the agency registered with its local County Clerk office.
  - A letter of intent on agency letterhead with the current date and the agency owner(s) written signature(s) that includes:
    - A list of the services the agency will provide and the county(ies) it intends to serve.
    - Names, email addresses, and phone numbers of the agency owner(s) and managing employee(s).

- A copy of Internal Revenue Service (IRS) correspondence confirming the agency's EIN.
- A completed, signed Home Help Agency Provider Employment Requirements form (HASA-2104). The MDHHS Home Help Policy Section includes the HASA-2104 in the agency application packet emailed to the agency. The HASA-2104 can also be accessed through the Forms Appendix.

Additional documents may be needed to clarify information received in the documents above. Applicants are encouraged to scan and email documents to the MDHHS Home Help Policy Section with the subject line of "Agency Application". Fax and mail are acceptable; however, confirmation that documents have been received is not available with these options. (Refer to the Directory Appendix for contact information.)

8.5.A. Approval Determination

Within 30 calendar days of the receipt of all required documents, the MDHHS Home Help Policy Section notifies the applicant in writing of its approval, denial, or the need for additional information.

An applicant is denied enrollment if any of the agency owners, agency representatives/ resident agents, or managing employees had direct or indirect ownership interest or control interest of an agency that was suspended or terminated from the Michigan Medicaid program within the preceding five years. (Refer to the Denial of Enrollment, Termination and Suspension [Termination or Denial of Enrollment] Section in the General Information for Providers chapter of this manual for more information.)

8.5.B. New Agency Provider Compliance Review

Once a new agency provider begins billing for Home Help services, it must undergo a compliance review. The MDHHS Home Help Policy Section will request the following documents three months after the first payment for Home Help services:

- A letter listing the agency owner(s) and managing employee(s), along with their email addresses and phone numbers, and the agency's correspondence address.
- A list of all agency caregivers currently providing Home Help services. The list must include each agency caregiver's name, individual CHAMPS provider ID, and the name(s) of the client(s) they serve.
- Three months of payroll records that must include agency caregiver names, pay period dates, payment amounts, Federal Insurance Contributions Act (FICA) withholdings, and proof of compliance with state unemployment insurance filings and payments. If payroll records do not verify tax payments, the agency provider may need to submit State of Michigan Form UIA 1028 and IRS Form 941.

Additional documents may be needed to clarify information received in the documents above. The MDHHS Home Help Policy Section will email the agency provider a letter listing the required documents. The agency provider is encouraged to scan and email documents to the MDHHS Home Help Policy Section with the subject line of "New Agency Compliance Review". Fax and

mail are acceptable; however, confirmation that documents have been received is not available with these options. (Refer to the Directory Appendix for contact information.)

8.5.C. Removal of Approved Agency Provider Status

MDHHS may revoke an agency provider's approved status if any of the following conditions are met:

- An agency provider fails to comply with Home Help policies.
- A new agency provider has not received payments for Home Help services within 12 months of its date of approval.
- An established agency provider has not rendered Home Help services within the last six months.

An unapproved agency provider remains eligible to provide services at the individual caregiver rate. The agency provider may contact the MDHHS Home Help Policy Section to request reinstatement of its approved status and the agency provider rate. (Refer to the Directory Appendix for contact information.)

8.6 General Provider Operating Standards

Providers must adhere to the following operating standards as a condition of participation in the Home Help program:

- Sign and retain a copy of the Home Help Services Agreement (MSA-4676) for every client. (Refer to the Home Help Services Agreement (MSA-4676) subsection for additional information.)
- Meet ASW interview requirements.
- Provide proof of identity.
- Comply with recruitment and marketing policies.
- Meet reporting requirements.
- Cooperate with the State of Michigan and MDHHS, or their designee, regarding any audits, investigations, or inquiries related to Home Help services provided.
- Comply with the privacy, security, and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information.
- Comply with Home Help provider policies.

8.6.A. Home Help Services Agreement (MSA-4676)

The Home Help Services Agreement form (MSA-4676) is an agreement between the client and the Home Help provider. It outlines the general service requirements and the Home Help provider's authorized tasks.

Individual caregivers and agency providers must sign an MSA-4676 for every Home Help client prior to delivering services. Payment cannot be authorized until the signed MSA-4676 is returned to the client's ASW or local MDHHS office.

The client must receive the MSA-4676 from the ASW and manages the form completion and submission. Once the client and provider sign and date the MSA-4676, it must be returned to the client's ASW or local MDHHS office. The form may be delivered in person or by fax, U.S. mail, or email. The client has the authority to decide how to return the completed MSA-4676 and may delegate the task to the provider.

An agency provider only needs to sign one MSA-4676 per client. A new MSA-4676 is not required when a new agency caregiver begins working with the client. The agency owner(s) may either sign the MSA-4676 or designate an authorized signer(s). Any individual who signs the MSA-4676 on the agency provider's behalf binds the agency provider to the terms outlined in the form. The agency owner(s) is responsible for ensuring the form is signed by an authorized signer. The authorized signer must be associated to the agency provider in CHAMPS or listed in "Step 9: Provider Controlling Interest/Ownership Details" of its CHAMPS enrollment.

The provider must retain a copy of the signed form in a secure location for seven years from the last date of services provided to the client.

8.6.B. Caregiver Interviews

Individual caregivers and agency caregivers must participate in an interview with the client's ASW at the start of service provision and every six months thereafter. At the start of service provision and at least once per year, the interview must be held in-person with the ASW. If phone or virtual (audio/visual only) contact was made at the last interview, an in-person contact with the ASW is mandatory for the next interview. (Refer to the Eligibility [Comprehensive Assessment] Section of this chapter for more information.)

Caregiver interviews are scheduled by the client's ASW and must occur during the review month. Follow-up by the caregiver may be needed if the ASW's initial attempt to schedule the review is unsuccessful.

NOTE: When an agency provider begins services with a client, the initial interview may be with the agency owner. Once services have begun, subsequent contact must be with the agency caregiver(s) providing the direct hands-on care to the client. Failure to cooperate with these requirements may result in suspension of payment to the agency provider.

8.6.C. Proof of Identity

Providers who have direct contact with clients must carry and present a picture identification that includes their name for verification. Providers must show their identification whenever requested by the client's ASW or other MDHHS staff working in collaboration with the Home Help program. Picture identification may include a driver's license or other state-issued identification, passport, or employee identification. An expired form of identification is acceptable if identity can be verified by the ASW or other MDHHS staff.

8.6.D. Recruitment and Marketing

Providers are prohibited from:

- Using materials developed by MDHHS in advertising, marketing, or recruitment in a manner that misrepresents the provider's relationship with the State of Michigan, MDHHS, or the Home Help program. The use of the MDHHS logo on provider documents is prohibited.
- Recruiting clients in MDHHS offices or anywhere on MDHHS premises. **NOTE**: Providers may conduct general advertising off MDHHS premises.
- Recruiting or directing advertising to clients currently receiving Home Help services.

Additionally, agency providers are prohibited from:

- Recruiting agency caregivers in MDHHS offices or anywhere on MDHHS premises. **NOTE**: Agency providers may conduct standard employee recruitment (e.g., posting job openings) off MDHHS premises.
- Recruiting or directing their advertising to individual caregivers who are currently providing Home Help services to one or more clients.
- Allowing an agency caregiver to provide services to a client who they were assisting as an individual caregiver for 90 days after commencement of employment with the agency provider or for 90 days after termination of services as the client's individual caregiver, whichever comes later.

8.6.E. Reporting Requirements

8.6.E.1. Changes Affecting Provider Enrollment

Providers must report all changes affecting their enrollment by updating their information in CHAMPS. This includes, but is not limited to, changes in address, contact name, or telephone number. Agency providers must also report changes in agency ownership, agency caregivers, and agency employees.

Failure to notify MDHHS within 10 calendar days of any changes may result in the termination of the provider's enrollment, denial of claims for services provided, and for agency providers, a reduction from the agency provider payment rate to the individual caregiver payment rate.

8.6.E.2. Changes Affecting Payment Authorization

Providers must notify MDHHS within 10 business days of any changes that affect the authorization of Home Help services payments, including but not limited to discontinuation of services, client hospitalization, or client admission to a nursing or AFC facility.

8.6.E.3. Mandated Reporter Requirements

Pursuant to MCL 400.11a, all Home Help providers are mandated reporters and must report suspected abuse, neglect, or exploitation of adults to Centralized Intake for Abuse and Neglect. (Refer to the Directory Appendix for contact information.)

8.7 Agency Provider Operating Standards

8.7.A. All Agency Providers

In addition to the requirements in the General Provider Operating Standards subsection in this chapter, all agency providers must adhere to the following operating standards:

8.7.A.1. Non-Competition Conditions

The agency provider must neither have, nor enforce, any agreements or requirements prohibiting an agency caregiver or agency employee from becoming an individual caregiver or working for another agency during or after their employment with the agency provider.

8.7.A.2. Record Retention Requirements

Agency providers must maintain supporting documentation verifying that services billed to MDHHS were provided to the client. At a minimum, this includes a copy of each client's Time and Task and verification of days and times worked, tasks completed, and names of clients that the agency provider worked with each day.

Records must be kept in a secure location for seven years from the date of service. Failure to produce supporting documentation for claims may result in recoupment of Home Help payments made to the agency provider. (Refer to the Record Keeping [Availability of Records] Section in the General Information for Providers chapter of this manual for more information.)

8.7.B. Approved Agency Providers

To retain approved agency provider status and remain eligible for the agency provider rate, agency providers must also adhere to the following operating standard:

8.7.B.1. Direct Hire Requirement

Approved agency providers must directly employ all agency caregivers and agency employees who work with Home Help clients. Medicaid will not reimburse an agency provider for services that were provided by a contracted agency caregiver. Agency caregivers and agency employees may not subcontract services to someone not directly employed by the agency provider. All agency caregivers and agency employees must be enrolled in CHAMPS and associated to the agency provider prior to providing Home Help services so that a criminal history check is completed.

(Refer to the Agency Provider Approval Process [Removal of Approved Agency Provider Status] Section of this chapter for more information.)

8.8 Service Verification

Providers must submit service verification monthly to receive payment. The service verification must be submitted on or after the last day services were provided for the month. Failure to submit a service verification within 365 days of the service date will result in non-payment. Providers are responsible for refunding overpayments resulting from the submission of an inaccurate service verification. Service verification may be reported through the following methods:

8.8.A. Home Help Agency Invoice (MSA-1904)

The agency provider must use the Home Help Agency Invoice (MSA-1904) to verify authorized services were provided. The MSA-1904 must include an accurate record of the Home Help services provided on each day of the billing period. The record must include only the services authorized for the client. A separate MSA-1904 must be submitted for each client served in a billing period. (Refer to the Forms Appendix for a copy of the MSA-1904.)

Payment is not released until the MSA-1904 has been received and verified by the client's local MDHHS office. (Refer to the Directory Appendix for contact information.) The MSA-1904 can be delivered in person or by fax, U.S. mail, or email.

8.8.B. Individual Caregiver Service Verification

8.8.B.1. Electronic Service Verification (ESV)

An individual caregiver with CHAMPS access must verify authorized services provided by submitting an electronic service verification (ESV) through CHAMPS. The individual caregiver must:

- Submit the ESV monthly. A separate ESV must be submitted for each client served during the month.
- Accurately report the services provided on each day of the month.

In addition to submitting the ESV monthly, the individual caregiver must report any change in services to the client's ASW within 10 business days.

An individual caregiver will ONLY be paid for:

- The tasks they provide and check on the ESV.
- Travel time they spend on laundry and/or shopping and check on the ESV.

An ESV can be modified as follows:

Adding Provided Tasks to the ESV	An individual caregiver who forgets to check a task(s) they provided or travel time they incurred before submitting the ESV may still be eligible for payment for these services. The individual caregiver must reopen the ESV, check the missed task(s) and/or travel time, then resubmit the ESV. MDHHS will issue a separate payment for the eligible tasks and/or travel time the individual caregiver added to the ESV. To be eligible for payment, tasks must be added and the ESV resubmitted within 365 days of the last date of service on the ESV. NOTE: If an individual caregiver receives a retroactive authorization for services and needs additional time to resubmit the ESV, they must contact the client's ASW.
Removing Tasks from the ESV that were Checked but not Provided	The ESV must include only the tasks an individual caregiver provided and can be corrected to remove tasks that were checked in error. An individual caregiver can only remove tasks from the ESV during the current month and before submitting the ESV. For previous months, the individual caregiver must provide the client's ASW with a list of tasks and/or travel time on the ESV that need to be removed. The ASW will use the information to recoup payment for services the individual caregiver did not provide.

8.8.B.2. PAPER SERVICE VERIFICATION (PSV)

An individual caregiver may be eligible to use a paper service verification (PSV) if the following criteria are met:

- There is no computer or internet access in the client and individual caregiver residence(s).
- Internet access is unavailable within 15 minutes of the client and individual caregiver residence(s). The individual caregiver must have a valid reason for being unable to travel to internet access, such as a lack of transportation or an inability to leave the client alone.

In addition to submitting the PSV monthly, the individual caregiver must report any change in services to the client's ASW within 10 business days.

An individual caregiver approved to submit PSVs must request PSV forms from the client's ASW or MDHHS Provider Support for atypical providers. PSV forms will be mailed to the individual caregiver's correspondence address in CHAMPS.

Each PSV form includes a barcode that corresponds to a service month and year. A PSV submitted for services in the wrong month and year will be rejected. The individual caregiver must contact the client's ASW or MDHHS Provider Support for atypical providers to request a new PSV. Payment will not be issued until the correct PSV is submitted.

Completed PSVs can be submitted by mail or fax. (Refer to the Directory Appendix for contact information.)

NOTE: PSVs usually take longer than ESVs to receive and process, which may lead to delayed payments.

8.8.C. Electronic Visit Verification

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. PCS provided through Home Help must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

8.9 Provider Payments

Providers must accept the authorized Home Help payment as payment in full. Clients must not be required or solicited to supplement Home Help payments for the same services authorized by MDHHS.

8.9.A. Payment Authorization

The client's ASW issues a provider Time and Task that includes a list of tasks the provider is authorized to perform. Payment is authorized based on the provider Time and Task. A provider must not receive payment for time spent on a task beyond what is authorized. With prior approval from the client's ASW, the provider's payment authorization may exceed the provider's Time and Task but may not exceed the client's Time and Task. Any changes to the provider's Time and Task must be approved by the client's ASW.

8.9.B. Payment for Travel Time

Providers authorized to assist with shopping or laundry may be eligible for payment for travel time up to:

- Two round trips each week for shopping.
- Two round trips each week for laundry.

Travel time is recorded as a separate item on the provider Time and Task and is in addition to the time authorized for shopping or laundry. Travel time is authorized only when the task is completed away from the client's or caregiver's residence. Payment for travel time cannot exceed the number of authorized trips on the provider Time and Task. The payment does not include the cost of mileage.

The amount allocated for travel time is based on normal, routine travel for the task being performed. Travel time must be incurred in the local area where the client's residence is located.

Travel time will be determined by the ASW at the client's initial comprehensive assessment and will be re-evaluated at each six-month review or when a change is reported. The amount of time approved by the ASW will be based on information obtained from the client and provider. Any change in the amount of travel time required must be reported to the client's ASW within 10 business days.

8.9.C. Payment Rates

Payment rates are published in ASM 138 Individual Caregiver and Agency County Rates, which can be accessed on the Home Help webpage. (Refer to the Directory Appendix for webpage information.)

8.9.C.1. Impact of Approval Status on Agency Provider Payment Rate

An agency must be designated an approved Home Help agency provider by MDHHS to be eligible for the agency provider rate. An unapproved agency provider is eligible to provide services at the individual caregiver rate. (Refer to the Agency Provider Approval Process [Removal of Approved Agency Provider Status] Section of this chapter for more information.)

8.9.D. Payment for Services Provided on the Client's Hospital Admission Date

A provider may be paid for Home Help services provided on the client's date of hospital admission if the client had active Medicaid on the date the services were provided and the provider:

- Provided the services on or after February 1, 2023.
- Provided the services before the time the client was admitted to the hospital.
- Provided the services in the client's home or workplace.

  NOTE: Laundry and shopping authorized to be done outside the client's home may be eligible for payment if completed before the time the client was admitted to the hospital.
- Logs the services provided on the service verification.
- Submits a completed, signed and dated BPHASA-2207 Home Help Billing for Hospital Admission Date form to the client's ASW or local MDHHS office as soon as possible after learning the client was admitted to a hospital but no later than 365 days from the date of service.

Refer to the Forms Appendix for a copy of the BPHASA-2207. It can also be downloaded from the Home Help webpage. Refer to the Directory Appendix for webpage information.

If the BPHASA-2207 is approved, payment will be based on the total amount of authorized time for the tasks documented on the provider's service verification. It will not be based on the time in and time out documented on the BPHASA-2207.

8.9.D.1. Submitting the BPHASA-2207 With the Service Verification

The provider may send the BPHASA-2207 to the client's ASW or local MDHHS office when they submit the service verification. The provider may submit the BPHASA-2207 any time after the client's hospital admission date but no later than 365 days later. The

BPHASA-2207 may be submitted in person or by fax, U.S. mail, or email. (Refer to the Directory Appendix for contact information.)

- Agency providers may send the BPHASA-2207 with the MSA-1904.
- Individual caregivers who use the ESV will need to send the BPHASA-2207 to the client's ASW or local MDHHS office after they submit the ESV.
- Individual caregivers who use the PSV must send the BPHASA-2207 separately from the PSV. The fax number and mailing address on the PSV will not route the BPHASA-2207 to the client's local MDHHS office.

NOTE: Hospitalization data is not always available when the client's ASW processes payment. If MDHHS finds that the time span on the BPHASA-2207 overlaps with the time the hospital reports the client was admitted to the hospital, MDHHS may recoup the portion of the Home Help payment for this day of service.

8.9.D.2. Submitting the BPHASA-2207 After the Service Verification

MDHHS will recoup payment for services provided on the client's hospital admission date if the service verification is not supported by a BPHASA-2207. A provider that does not submit the BPHASA-2207 with their service verification should send the BPHASA-2207 to the client's ASW or local MDHHS office as soon as possible. If a provider does not submit the BPHASA-2207 in time to avoid recoupment, they may use the form to request repayment of recouped funds.

8.9.E. Individual Caregiver Payments

8.9.E.1. Warrants Payment System

Home Help payments are issued as dual-party warrants to the client and individual caregiver and mailed to the client's address. Home Help warrants must only be endorsed by the person(s) listed on the warrant. If the individual caregiver named on the warrant does not provide services or provides services for only a portion of the authorized period, the warrant must be returned.

There are circumstances when a single-party warrant may be issued to the individual caregiver only. For example, a client may be physically or cognitively unable to endorse the warrant. Single-party warrants must be authorized by the client's ASW.

NOTE: All agency provider payments are issued as single-party warrants.

8.9.E.2. Garnishment

Garnishment is a court process that allows a creditor to collect an individual caregiver's debt from the State of Michigan. Single-party warrants are considered earnings to the individual caregiver and are subject to garnishment. Dual-party warrants are considered a benefit to the client and are not subject to garnishment.

NOTE: Recoupment of overpayments for Home Help services is a different process from garnishment. MDHHS recoups overpayments from both single- and dual-party warrants.

8.9.E.3. IRS Form W-2 Wage and Tax Statement (W-2)

On behalf of the client, MDHHS issues a W-2 for the individual caregiver. The W-2 is based on wages paid in a calendar year. If inaccurate earnings have been reported, an individual caregiver can report this fact to the ASW or call MDHHS Provider Support for atypical providers. (Refer to the Directory Appendix, Provider Assistance, for more information.)

8.9.E.4. FICA Tax Withholding

As the client's filing agent, the State of Michigan withholds FICA taxes from the wages paid on the client's behalf to the individual caregiver(s). MDHHS pays the amount of FICA tax the client is responsible for and withholds the individual caregiver's portion from the Home Help payment. At the end of the calendar year, the State of Michigan issues a FICA tax rebate warrant to any individual caregiver who earns less than the gross income limit set by the federal government.

FICA tax is not withheld from payments, and the State of Michigan does not pay the FICA tax employer portion, when the individual caregiver is:

- The client's parent (including a step, adoptive, or foster parent).
- A child between the ages of 18 and 20 providing Home Help services to a parent.

NOTE: The State of Michigan can withhold FICA tax from payments to a parent serving as their child's individual caregiver. An individual caregiver interested in this option should speak with the client's ASW.

A client who is a Medicaid deductible beneficiary is responsible for the FICA taxes on any Home Help provider payments they make to meet their deductible. The State of Michigan does not withhold and pay the employer portion of FICA taxes on these payments. (Refer to the Eligibility [Medicaid Eligibility] Section in this chapter for more information.)

8.10 Agency Provider Audits

The MDHHS Home Help Policy Section conducts desk audits of a sample of agency providers each year to monitor compliance with program requirements. The MDHHS Home Help Policy Section initiates the audit by emailing a letter to the agency provider outlining the required information. The agency provider must submit documents within 30 calendar days of the date of the letter and is encouraged to scan and email documents to the MDHHS Home Help Policy Section with the subject line of "Home Help Audit". Fax and mail are acceptable; however, confirmation that documents have been received is not available with these options. (Refer to the Directory Appendix for contact information.)

Failure to provide required information by the due date may result in a rate reduction. Failure to provide required information within 60 calendar days results in the agency provider losing its approved status for a minimum of 30 calendar days or until compliance, whichever is longer.

Other authorized areas within MDHHS may also request documents or other records needed for the Home Help program. Agency providers must follow the timelines specified in those requests.

8.11 Provider Disenrollment

8.11.A. Voluntary Disenrollment

A provider may choose to withdraw from participation in the Home Help program. To disenroll, the provider must email the MDHHS Home Help Policy Section or the MDHHS Provider Enrollment Unit with notice of intent to disenroll and the date of disenrollment. (Refer to the Directory Appendix for contact information.)

8.11.B. Involuntary Disenrollment

When MDHHS disenrolls a provider, authorizations for Home Help payments are terminated. Notice is sent to the provider and the local MDHHS office within 10 calendar days of the determination of disenrollment. MDHHS may disenroll a provider who:

- Has been found guilty of Medicaid fraud or client abuse, exploitation, or neglect. **NOTE**: An agency provider may be disenrolled if an agency caregiver or agency employee meets this criterion.
- Falsifies information in the application documents, provider agreement, quarterly reporting, service verification, or billing.
- Has been convicted of a crime(s) that excludes the provider from Medicaid participation. (Refer to the Denial of Enrollment, Termination and Suspension [Termination or Denial of Enrollment] Section in the General Information for Providers chapter of this manual for more information.) **NOTE**: An agency provider may be disenrolled if an agency owner, agency representative/resident agent, or member of the Board of Directors meets this criterion.
- Fails to report changes or update CHAMPS enrollment within 10 calendar days of the change.
- Fails to comply with policies governing the Home Help program.

A provider may be suspended if they are being investigated for fraud, abuse, exploitation, or neglect, pending the outcome of the investigation.

SECTION 9 – APPEALS

Any questions regarding the following appeal processes should be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix, Appeals, for contact information.)

9.1 CLIENT APPEALS

A client or their authorized hearing representative may appeal an eligibility determination, service approval or negative action by requesting an administrative hearing. A provider cannot request an administrative hearing on behalf of a client. (Refer to ASM 150 for more information. A link to the ASM Table of Contents is available in the Directory Appendix.)

9.2 PROVIDER APPEALS

All providers may appeal the following negative actions by requesting an administrative hearing:

- Enrollment suspension.
- Disenrollment.
- Payment recoupment.

Agency providers may also appeal the following negative actions by requesting an administrative hearing:

- Denial of a new agency application.
- Removal of approved agency provider status.
- Reduction in the payment rate.

Refer to the Provider Appeal Process Section in the General Information for Providers chapter of this manual for more information.

9.2.A. CURRENT PROVIDERS

MDHHS will inform a provider of a negative action through a negative action notice. The provider may appeal to MOAHR within 30 calendar days of the date on the notice. The provider may continue to provide services during the appeal period if it accepts responsibility for the repayment of funds should the MDHHS decision be upheld. The provider may not accept new clients during the appeal period. During this time, the client continues to have the right to terminate the provider at any time and without cause.

NOTE: The process described above may not reflect actions taken on behalf of MDHHS by the MDHHS Office of Inspector General (OIG). A provider suspended from the Home Help program by OIG cannot operate during the suspension and has 15 calendar days to appeal the OIG decision.

9.2.B. Provider Applicants

MDHHS will send a notice to the provider applicant that summarizes ineligibility factors identified through screening or evaluation. The provider applicant may appeal to MOAHR within 30 calendar days of the date of the notice. Provider applicants denied enrollment are not eligible to receive MDHHS payments for Home Help services during the appeal period.

HOSPICE

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SECTION 1 - INTRODUCTION

This chapter applies to Hospice providers.

Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity and quality of life. Hospice is intended to address the full range of needs of the individual with a terminal illness, while also considering family needs. Care must be consistent with the individual's values, regardless of the location where care is provided.

The primary objective of the Medicaid Hospice Program is to ensure that essential medical/health services are available to those who would not otherwise have the financial resources to purchase them. Medicaid policies are designed to achieve this objective with fiscal responsibility. Hospice providers must verify eligibility before providing services. Hospice beneficiaries are identified in the eligibility response with the Benefit Plan ID of Hospice. (Refer to the Beneficiary Eligibility chapter for additional information.)

SECTION 2 - PROVIDER REQUIREMENTS

Hospice providers are bound to all rules, regulations, and policies specified in this chapter for program participation/enrollment of Medicaid beneficiaries. Hospice providers must also comply with the Medicare Conditions of Participation (42 CFR § 418) which generally apply to non-Medicare beneficiaries as well as to Medicare beneficiaries.

Additional information regarding federal Hospice requirements and guidelines is contained in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual 2083.

The exceptions are 42 CFR § 418.60 and 42 CFR § 418.98(c) conditions that apply only to Medicare beneficiaries.

Michigan Department of Health and Human Services (MDHHS) requires Hospice agencies to be licensed in Michigan by the state-licensing agency, certified by Medicare, and enrolled in Medicaid. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Hospice providers cannot engage in any of the following marketing-related practices:

- Provide cash, gift incentives, or rebates to prospective covered persons;
- Claim superior medical care or provider skills; or
- Make untruthful statements regarding the merits of the hospice.

The use of marketing practices that mislead, confuse, or defraud either the beneficiary or MDHHS is considered grounds for terminating the hospice from participation in Medicaid. Such actions may also result in investigation leading to possible prosecution under applicable State and Federal statutes.

SECTION 3 - BENEFICIARY ADMISSION

3.1 BENEFICIARY ADMISSION DETERMINATION

A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, has the option for admission into a hospice program. A representative, such as a spouse, parent, legal guardian, or other authorized adult, may act on behalf of the beneficiary.

Medicaid does not cover Hospice services if the following conditions exist:

- The individual is not eligible for the Medicaid benefit.
- The beneficiary does not meet the hospice's admission criteria.
- If the beneficiary is currently enrolled in a Medicaid Health Plan (MHP), the hospice services must be arranged and reimbursed by the MHP.

All Hospice admission activities must be conducted according to MDHHS policies and in such a manner as to maximize the beneficiary's ability to make a choice between admission into hospice or maintaining current active treatment with Medicaid coverage. Such activities must assure that the beneficiary fully understands how to use hospice services and that all care must be received from or through the hospice (except those services not related to the terminal illness or services provided by their attending physician).

It is imperative that the Hospice provider review the Conditions of Admission with the beneficiary and answer any questions raised by the beneficiary and/or authorized representative.

3.2 BENEFICIARY ADMISSION PROCESS

Hospice providers are responsible for admitting beneficiaries for hospice services in the Admission Information Section in CHAMPS. The admission process must be electronically completed in CHAMPS. A downloaded copy of the beneficiary's admission must be signed by the beneficiary and/or authorized representative, with a copy given to the beneficiary and/or authorized representative and the original copy retained in the beneficiary's record. Completion of the hospice beneficiary's admission in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's Program Enrollment Type (PET).

Hospice providers have the ability to track their current beneficiaries in CHAMPS via the Member Enrollment/Admission List screen. This roster screen will allow the provider to view beneficiary admission information and Medicaid status. Hospice providers must complete the hospice admission in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

A copy of the following information must be retained in the beneficiary's record:

- The original, signed copy of the Admission Certification.
- Hospice identification card (if the hospice chooses to issue one to their beneficiaries).

3.3 Beneficiary Notification

Hospice providers must provide Medicaid beneficiaries with the following materials and written information within ten days of the effective date of admission into hospice:

- Conditions of admission, including:
  - Scope, content, and duration of coverage;
  - Beneficiary grievance procedure; and
  - Beneficiary responsibility for reporting coverage by any other insurance.
- Procedures for obtaining health care, including:
  - Address, telephone number, and service hours of the health care providers;
  - Emergency medical care (other than for the treatment of the terminal illness); and
  - Health care provision outside of the hospice.

3.4 Place of Service

3.4.A. Beneficiary's Home

A beneficiary eligible for hospice may receive hospice services in their home. If the beneficiary is eligible for hospice services but does not have family or friends to provide the necessary home care, the beneficiary may live in a residential setting that may include an Adult Foster Care (AFC) facility, boarding home, Home for the Aged (HFA), or assisted living facility. The setting must be appropriate for the type of care required by the beneficiary. Medicaid does not pay room and board in these settings.

Beneficiaries may receive hospice services in these settings. The hospice is responsible for developing and implementing a coordinated plan of care to avoid duplication of services. These care settings are available for Medicare, Medicaid, and dually eligible beneficiaries.

3.4.B. Nursing Facility

When a dually enrolled Medicare/Medicaid beneficiary enters a nursing facility (NF), the beneficiary can elect the Medicare hospice benefit if that NF has hospice services available. In this case, the beneficiary revokes the 100 days of Medicare reimbursement for skilled NF care.

Revocation of the 100-day NF skilled care is a beneficiary's decision and should not be influenced by the NF's funding source for the bed.

The CHAMPS application process is used to complete the beneficiary's election for hospice and create the correct PET (e.g., HOS-NFAC) for Medicaid eligible beneficiaries. This does not mean that the beneficiary has revoked the Medicare benefit for services not related to their terminal illness. The beneficiary remains eligible for Medicare, but has elected to use only the hospice portion of the Medicare benefit.

If the NF contracts to make hospice services available, the hospice must complete the admission in CHAMPS for all Medicaid, Medicare and dually eligible beneficiaries. The facility must provide room and board for the beneficiary, and the hospice must provide its normal services.

The Pre-Admission Screening/Annual Resident Review (PASARR) form (DCH-3877) must be completed for a hospice patient entering a NF unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on antipsychotic or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medications for a related mental illness, the CMHSP will determine the need for a Level II screening.

Medicaid will reimburse the hospice for room and board for a hospice beneficiary who resides in a NF (including a beneficiary for whom a complex care authorization has been approved) or in a Ventilator Dependent Care Unit (VDCU). The hospice then reimburses the NF. The Medicaid reimbursement to the hospice for NF room and board is equal to 95% of the total Medicaid NF rate. For Class I, III, and V facilities, reimbursement also includes 100% of the Quality Assurance Supplement (QAS) amount due the NF through the Quality Assurance Assessment Program (QAAP). QAS funds are not included in the reimbursement for Hospital Swing Beds as they are not eligible for that program.

Per Medicare guidelines, the term "room and board" in a NF includes the performance of personal care services that a family caregiver would provide if the individual were at home. This includes assistance in the activities of daily living such as bathing, grooming, toileting, dressing, meal service, socializing, companionship, hobbies, administration of medication, maintaining the cleanliness of the beneficiary's bed and room, and supervising/assisting in the use of durable medical equipment (DME) and prescribed therapies (e.g., range of motion, speech and language exercises). The NF may not include hospice staff to meet its staffing requirements.

Hospice covered beneficiaries residing in the NF must not experience any lack of NF services or personal care due to their status as a hospice beneficiary. NFs must offer the same drugs, services, medical supplies and DME to all residents who have elected the hospice benefit in the same manner that services are provided to other residents in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

3.4.C. Hospital Inpatient Care

Medicaid hospice reimbursement includes payment for any hospitalizations related to the terminal illness. The hospice must contract with, and reimburse, a hospital for medically necessary inpatient services related to the beneficiary's terminal illness. Medicaid does not reimburse the hospital separately unless the hospitalization is not related to the terminal illness.

3.5 Duration of Coverage

Based on hospice eligibility criteria, the duration of hospice services is generally six months or less. There is no minimum period of hospice admission. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel their admission in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while admitted in a hospice also become ineligible for Medicaid reimbursement for hospice services.

SECTION 4 - BENEFICIARY DISCHARGE

A beneficiary may be discharged from hospice as noted below. The provider must complete the Discharge webpage in CHAMPS. The discharge must indicate the type of discharge, date of the discharge, reason, and details of the beneficiary's residence after discharge. A downloaded copy of the beneficiary's discharge (voluntary or involuntary) must be signed by the beneficiary and/or authorized representative as proof of notification (unless the beneficiary has expired). A copy must be given to the beneficiary and/or authorized representative after they sign it.

Terminations generated by the hospice are subject to the appeal procedures, as required by licensure requirements.

Completion of the hospice beneficiary's discharge in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET.

Hospice providers must complete the hospice discharge (voluntary or involuntary) in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

4.1 BENEFICIARY DIES

When a beneficiary dies while admitted in hospice, the hospice must complete the discharge in CHAMPS indicating the date the beneficiary expired.

4.2 BENEFICIARY ELECTS TO VOLUNTARY DISCHARGE/REVOKES THEIR HOSPICE BENEFIT

A beneficiary may elect voluntary discharge from, or revoke their election of, hospice care at any time during an election period. The hospice must obtain written documentation, signed and dated by the beneficiary or their authorized representative, stating they are revoking the hospice benefit for the remainder of that election period. The voluntary discharge or revocation is effective with the date of the beneficiary's/representative's signature. The hospice must complete the discharge in CHAMPS, give a copy of the discharge notice to the beneficiary or authorized representative after they sign it, and retain the original copy in the beneficiary's record.

4.3 HOSPICE REVOCATION OR DISCHARGE WHEN BENEFICIARY IS HOSPITALIZED

A beneficiary should **not** revoke or be discharged from hospice for the purpose of admission to the hospital for care related to the hospice diagnosis. Medicaid does not reimburse the hospital separately unless the hospitalization is **not** related to the terminal illness. When this is the case, the hospice may continue to provide care to the beneficiary under the routine hospice care benefit.

4.4 BENEFICIARY NO LONGER MEETS ADMISSION CRITERIA

A beneficiary may have a change in condition and no longer qualify for hospice services. If the beneficiary is discharged for this reason, the hospice must complete the discharge in CHAMPS, provide the date of the discharge, and indicate the reason in the Remarks section of the webpage for the

discharge. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.

4.5 Beneficiary Becomes Ineligible for Medicaid

The hospice is responsible for verifying the beneficiary's continued Medicaid eligibility once they are enrolled. Medicaid does not reimburse hospice services rendered to a Medicaid ineligible beneficiary. Once the beneficiary is deemed no longer eligible for hospice services, the hospice must complete the discharge in CHAMPS and indicate in the Remarks section the reason why the beneficiary is no longer eligible for hospice services. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.

4.6 Beneficiary Moves Outside the Hospice Service Area

At the time of the hospice admission, beneficiaries must be told to notify the hospice and their local MDHHS worker if their place of residence changes. If the new residence is located in the hospice's normal service area, or if the hospice agrees to continue to provide services to the beneficiary, the move creates no changes except an address change. If the move is too far for the hospice to continue services for the beneficiary, the hospice must arrange a transfer of care for the beneficiary to another Medicaid enrolled hospice. The two hospices must work together to assure that no lapse occurs in services to the beneficiary.

The first hospice must complete the discharge webpage and indicate the planned date of admission for the second hospice in the Remarks section. It is then the responsibility of the second hospice to complete the admission application in CHAMPS. Each hospice must place an explanation in the Remarks section stating the reason for the transition.

4.7 Hospice Elects to Terminate the Beneficiary's Admission

The hospice may discharge a beneficiary if the beneficiary violates any of the conditions of membership in the hospice. The decision to discharge a beneficiary and the effective date of the discharge are determined on an individual basis by the hospice Medical Director.

The hospice may request discharge of a beneficiary for any of the following reasons:

- Fraud;
- Abuse (including repeated instances of willfully and knowingly obtaining health care services for the terminal illness from non-hospice providers); or
- Misconduct (including violence that interferes with or interrupts the provider's proper delivery of health care to the patient or other patients).

SECTION 5 - MEDICARE CONDITIONS OF PARTICIPATION

5.1 HOSPICE ELECTION PERIODS

The duration of hospice coverage is measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; or
- An unlimited number of subsequent 60-day periods.

5.2 CERTIFICATION OF THE TERMINAL ILLNESS

A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted. If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification. Statements covering a beneficiary's initial certification must be obtained from the hospice medical director or the physician member of the Interdisciplinary Group (IDG), and the beneficiary's attending physician if the beneficiary has an attending physician. The hospice medical director or the physician member of the IDG certifies the terminal illness for all subsequent election periods.

Each written certification must include:

- A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation as needed to support the life expectancy of six months or less;
- A brief narrative summary;
- An explanation why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (beginning with the third benefit period and thereafter); and
- Physician signature(s), date signed, and specific election period dates covered by the certification or recertification.

Documentation of all written/verbal certifications must be prepared no more than 15 calendar days prior to the effective date of election and must be kept in the beneficiary's medical record.

5.3 NARRATIVE SUMMARY

Each hospice certification and recertification must be accompanied by a brief narrative describing the clinical findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain checkboxes or non-specific, standard language.

5.4 Face-to-Face Encounter

The physician or permitted non-physician practitioner (NPP) must have a face-to-face encounter with every hospice beneficiary prior to the 180th day of recertification of the beneficiary's terminal illness for the purpose of determining continued eligibility. The 180th day recertification is defined as the recertification that occurs at the start of the third benefit (election) period or the benefit period following the second 90-day benefit period. Additionally, a face-to-face must be conducted at each subsequent recertification (every 60 days thereafter) for as long as the beneficiary is in hospice. Face-to-face encounters must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to each subsequent benefit period thereafter.

Permitted NPPs include:

- A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with State law.
- A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician.

The physician or NPP must attest in writing to the face-to-face encounter with the beneficiary and include the date of the visit. An NPP is allowed to perform and attest to the face-to-face encounter; however, the initial certification for hospice must be completed by a physician.

Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should occur, the hospice must complete the admission in CHAMPS, with the last date of the benefit period as the effective discharge date. A comment in the Remarks Section on the Discharge webpage is required to explain the reason for the discharge.

It is the responsibility of the first hospice to complete the discharge in CHAMPS before the second hospice can complete the admission in CHAMPS when:

- the beneficiary discharges from one provider for admission to a new provider;
- the beneficiary revokes the services of a provider; or
- the provider discharges the beneficiary.

The new hospice provider may begin their care within the beneficiary's first benefit period.

In the event a hospice provider is resuming care for a beneficiary formerly served by their hospice, the resuming hospice provider must have previously completed the discharge in CHAMPS at the time hospice services originally ended. To resume care, the hospice must complete a new admission in CHAMPS. The resumption of care starts in the next or subsequent benefit period.

SECTION 6 - HOSPICE SERVICES

6.1 CORE SERVICES

The hospice must provide all or substantially all of the core services applicable for the terminal illness in the beneficiary's home. (Home may include the beneficiary's private dwelling, apartment, boarding home, assisted living facility, AFC facility, HFA, NF or hospice-owned NF.)

These core services are:

- Physician care
- Nursing care
- Social work
- Counseling
  - Bereavement
  - Spiritual
  - Dietary

6.2 OTHER HOSPICE COVERED SERVICES

Other services that may be necessary due to the terminal illness and must be available but are not considered core services are:

- Drugs*/Biologicals
- Home Health Aide services
- Homemaker services
- Medical Supplies/Durable Medical Equipment (DME)
- Occupational Therapy
- Physical Therapy
- Short-Term Inpatient care
- Speech Therapy

***Although the drug AZT (Retrovir) is related to the terminal illness of AIDS, MDHHS reimburses the pharmacy separately for a hospice beneficiary receiving AZT.**

These other services may be provided by contractual agreement or provided by the hospice directly and are not reimbursed separately.

6.3 Suspected Abuse/Neglect

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the hospice must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

6.4 Transportation

6.4.A. Home Setting

Non-emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, non-emergency transportation to obtain Medicaid covered services not related to the terminal illness is available through the local MDHHS office for beneficiaries who do not reside in a nursing facility (NF). The beneficiary/responsible party should contact the MDHHS worker to determine the appropriate mode of non-emergency transportation and make the necessary arrangements. The transportation provider, not the hospice, bills the local MDHHS office for the transportation provided.

Non-emergency transportation by ambulance not related to the terminal illness requires a physician's signed order to allow the ambulance provider to bill Medicaid directly.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.

6.4.B. Nursing Facility Setting

Non-emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, non-emergency transportation not related to the terminal illness must be provided by the NF as part of their per diem.

Non-emergency ambulance transportation not related to the terminal illness requires a signed physician's order and may be billed directly to Medicaid by the ambulance provider. If the NF does not have a physician's order, neither the NF nor the ambulance provider can bill Medicaid, the beneficiary, the beneficiary's family, or use the offset to the patient pay amount. Arrangement for payment is between the NF and the ambulance provider.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.

6.5 Hospice Service Log

The hospice must complete a detailed monthly service log that indicates the services provided to the beneficiary and whether an employee or a volunteer provided them. Each service (e.g., nursing, social work, hospice aide) must be logged by the date on which it took place.

The log must be retained as part of the beneficiary's medical record. However, if the hospice maintains this information electronically in a secure, yet readily understood format, it is not necessary to maintain a paper copy of the log.

6.6 Categories of Care

There are four categories of hospice care:

Routine Home Care	Routine Home Care is defined as hospice home care that is not continuous.
Continuous Home Care	Continuous Home Care is defined as short-term in-home care that is reflective of at least half of the hours predominantly being nursing care provided by either a registered nurse or licensed practical nurse in a crisis situation. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home hospice care. Payment is made for the hours of continuous care provided, up to 24 hours in one day.
Inpatient Respite Care	Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s) providing at-home hospice care for the beneficiary. Hospice care may be provided in a licensed hospice residence, hospital, or NF meeting hospice standards for staffing and patient areas. The length of stay may not exceed five consecutive days.
General Inpatient Care	General inpatient care is covered when the beneficiary's condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. It is defined as short-term inpatient care provided in a licensed hospice residence, hospital, or NF meeting hospice standards for staffing and patient areas. This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot be reasonably treated in another setting. General inpatient care is not to be used solely if a beneficiary requires care in a facility setting. Michigan Medicaid provides payment for room and board in a nursing facility if the beneficiary's hospice care would be more appropriately provided in this setting under the routine hospice benefit.

Guidelines for core and other services (as detailed above) apply to all categories of care.

6.7 Plan of Care

After admission in the hospice, a person-centered plan of care (POC) must be developed before the beneficiary can receive services. It is also the responsibility of the hospice provider to determine if the beneficiary is receiving services from another program such as Home Help, MI Choice Waiver, or Private Duty Nursing (PDN). If another program is identified, the hospice provider must contact the other program(s) and develop a joint POC to coordinate services. The beneficiary and/or authorized representative or primary caregiver and the Interdisciplinary Group (IDG), as defined by federal

regulations, must also participate in the development of the plan. The beneficiary's attending physician or NPP should be encouraged to attend as well. The hospice is responsible for implementing the POC for hospice services.

6.7.A. Adult Foster Care Facility/Home for the Aged

The Adult Foster Care Facility/Home for the Aged (AFC/HFA) is responsible for care related to the non-terminal needs of the beneficiary who resides in their facility. There is to be no duplication of services by either staff.

6.7.B. Assisted Living Facility

The hospice is responsible for implementation of the POC for hospice services provided in this setting.

6.7.C. Nursing Facilities

The NF and hospice are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed POC. The joint POC must include directives for managing pain and other uncomfortable symptoms, and be revised and updated as necessary to reflect the beneficiary's current status. The hospice retains overall professional management and responsibility for directing the implementation of the POC.

The joint POC should reflect the participation of the hospice, NF, and the beneficiary to the extent possible. The hospice and NF must communicate with each other when any changes to the POC are indicated, and each provider must be aware of the other's responsibilities in implementing the POC. There must be evidence of this coordination of care in the clinical records of both providers. All aspects of the joint POC must reflect the hospice philosophy. NF services must be consistent with the POC developed in coordination with the hospice.

6.7.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)

If the beneficiary is enrolled in the waiver program, the hospice must contact the beneficiary's waiver coordinator/agent. A joint POC must be retained in the beneficiary's record by both the hospice and the waiver coordinator. The hospice is the primary provider and manages the joint POC. The POC must clearly identify the services the beneficiary receives, which entity is responsible for providing the services, and the frequency of the services to be provided. Each waiver service included in the POC should be accompanied by documentation stating why the service is not covered under hospice. The waiver coordinator must understand the hospice philosophy so that the two agencies work for a common goal and eliminate duplicate services. Ongoing communication and coordination must occur regularly between the two providers during the time they are serving the same beneficiary. Written documentation of this ongoing communication and coordination must be kept in the beneficiary's record at each agency.

Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative.

If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services. It is the responsibility of the waiver agent to complete the beneficiary's MI Choice waiver enrollment in CHAMPS. However, if the beneficiary is receiving waiver services and becomes eligible for hospice, it is the responsibility of the hospice to complete the hospice admission in CHAMPS. The appropriate Program Enrollment Type (PET) identifies a beneficiary receiving hospice services and Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) services concurrently (e.g., MIC-HSSP). The waiver agency and the hospice provider must discuss and coordinate services in order to prevent delays in access of care.

Hospice services must be used to the fullest extent before additional waiver services of the same type are provided. Post-payment review may be employed to monitor services. If inappropriate (e.g., duplicative) waiver services were provided, MDHHS will seek recovery of Medicaid funds paid for those services from the waiver coordinator.

MDHHS maintains a list of MI Choice waiver coordinators and contact information on the MDHHS website. (Refer to the Directory Appendix for website information.) Habilitation Supports waiver coordinators may be contacted through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) provider.

6.7.E. Private Duty Nursing

If a beneficiary receiving private duty nursing (PDN) becomes eligible for hospice, the hospice is required to notify the MDHHS Program Review Division before a claim is submitted for the services. (Refer to the Directory Appendix for contact information.)

The hospice must provide the following information on agency letterhead to the Program Review Division:

- beneficiary name and Medicaid ID number;
- a request for a case review and approval of hospice services;
- a statement confirming that the beneficiary has been certified terminally ill with six months or less to live, signed by the hospice medical director and the beneficiary's attending physician; and
- name, e-mail address, and telephone number of the contact person.

Program Review Division staff may request additional medical record documentation for their review. If services are approved, the hospice must work with the PDN agency to develop a coordinated plan of care. Both the hospice and PDN staff must ensure that duplication of services does not occur. While hospice maintains the lead in coordinating the services, the PDN agency must continue to obtain prior authorization from MDHHS for the PDN services.

This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21, or the MI Choice Waiver. For beneficiaries under the HSW, providers should contact the beneficiary's case manager to inform them of

hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.

6.8 Concurrent Hospice and Curative Care for Children

Children under 21 years of age may receive hospice care concurrently with curative treatment of the child's terminal illness. This allows the beneficiary or beneficiary's representative to elect the hospice benefit without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition. The need for hospice care must by certified by a physician and the hospice medical director.

Under concurrent curative care policy, curative care is defined as medically necessary care that serves to eliminate the signs and symptoms of a disease with the goal of a cure or long-term disease-free state.

Medicaid will reimburse for the curative care separately from the hospice services. Medicaid will not reimburse for these types of treatments when they are used palliatively. Palliative care under hospice is defined as an active patient and family-centered interdisciplinary approach to pain and symptom management of the terminal illness. Palliative care is always a part of hospice and included in the hospice per diem reimbursement. The term "palliative care" cannot be separately billed or reimbursed by Medicaid.

A child receiving hospice will continue to receive appropriate early and periodic screening, diagnosis and treatment (EPSDT) services to the extent these services are medically necessary.

Pediatric Subspecialist	A pediatric subspecialist must direct the curative care related to the beneficiary's terminal diagnosis. For purposes of this policy, a pediatric subspecialist is a physician or permitted NPP who is board certified, or board eligible for subspecialty certification, in a pediatric subspecialty including, but not limited to, neurology, cardiology, pulmonology, endocrinology, or oncology. In most cases, a general pediatrician will not be considered a pediatric subspecialist relative to this policy, but a general pediatrician may assume the role of pediatric subspecialist and direct the child's curative care if they have acted as the primary care provider and treated the child's terminal condition prior to the election of hospice. NOTE: Beneficiaries with CSHCS-only coverage, meaning no Medicaid coverage and receiving hospice related to the CSHCS qualifying condition, must have a pediatric subspecialist for that condition manage the concurrent curative treatment of the terminal condition.
Coordination of Care	The hospice provider and pediatric subspecialist must work together to ensure a collaborative approach to the care of the beneficiary. The hospice Plan of Care (POC) must demonstrate coordination of care between the hospice and the pediatric subspecialist. It is the responsibility of each provider working collaboratively to determine whether a service is curative or palliative (hospice). The hospice record must contain a signed statement or attestation from the pediatric subspecialist explaining the course of treatment and acknowledging the physician is aware the beneficiary is receiving hospice services concurrently with curative treatment. The attestation must be dated and present in both the hospice and pediatric subspecialist records within 30 days after the beneficiary is admitted into hospice. The signature, printed name, and National Provider Identifier (NPI) number of the physician ordering and coordinating the concurrent curative treatment must be documented on the attestation. For a beneficiary enrolled in a Medicaid Health Plan (MHP), the hospice provider and pediatric subspecialist must also work with the MHP to ensure that the MHP authorization and documentation requirements are met.

Billing and Reimbursement	Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. MDHHS recognizes the challenge this poses for providers, and each child's circumstances will need to be taken into consideration when making this distinction. The table below provides examples of treatment and related service categories but is not all-inclusive or intended to represent fixed parameters for decision making. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.

Examples of Treatment and Service Categories

Treatment	Hospice Service	Concurrent Curative Service	Both Hospice and Concurrent Curative Services	Comments
Pain/Symptom Management				
Narcotics, Analgesics	X			
Antiemetics	X			
Nutrition				
Tube Feeding			X	Hospice = Continuation of previous tube feedings. Concurrent = Tube placement; initiating feedings.
Intravenous (IV) Fluids		X		Concurrent = Surgical central line placement
Total Parenteral Nutrition (TPN)		X		
Respiratory Support				
Oxygen	X			
Bilevel Positive Airway Pressure (BiPAP)			X	Hospice = <72 hrs. Concurrent = Acute event not related to terminal illness
Continuous Positive Airway Pressure (CPAP)			X	
Ventilator		X		

Treatment	Hospice Service	Concurrent Curative Service	Both Hospice and Concurrent Curative Services	Comments
Respiratory Vests			X	
Cough Assist Device(s)			X	
Pharmacy				
Antibiotics	X			Antibiotic administration through available access
Chemotherapy		X		
Intravenous immunoglobulin		X		
Blood Products		X		
Supports				
Spiritual Support	X			
Psychological/Social Support	X			
Bereavement Support	X			
Radiation		X		
Durable Medical Equipment (DME)				
Specialized Seating		X		
Wheelchairs	X			

6.9 Special Programs

6.9.A. Home and Community Based Waiver Beneficiaries (Children's Waiver, Habilitation Supports Waiver)

If waiver services are not related to the terminal illness, the hospice should send the MDHHS waiver program coordinator an explanation of the situation when enrolling the beneficiary. The hospice agency should contact the waiver case manager or supports coordinator at the PIHP/CMHSP to coordinate care and to develop a combined POC.

6.9.B. Children's Special Health Care Services (Title V)

Refer to the Children's Special Health Care Services chapter, Hospice Benefit section, for policy information.

6.9.C. Children's Special Health Care Services/Medicaid (Title V/XIX)

Hospice services for children covered under Children's Special Health Care Services (CSHCS) and determined Medicaid eligible (Title V/XIX) follow Medicaid policy outlined in this chapter.

6.9.D. MI Health Link

Beneficiaries enrolled in MI Health Link are dually eligible for both Medicare and Medicaid. While hospice is not a benefit offered by MI Health Link, beneficiaries in the program may still elect hospice and begin receiving hospice services at any time.

Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose.

(Refer to the MI Health Link Chapter for additional details regarding hospice services under the MI Health Link program.)

6.10 Home Help/Personal Care

Home Help services may be available to the hospice beneficiary living at home (e.g., not residing in a hospice residence, NF, AFC, etc.). It is important that hospice services be utilized first, prior to Home Help services. Home Help services may be in addition to hospice care and must not duplicate hospice services. Home Help services include assistance with ADL, IADL, and complex care tasks. Some examples of when these services are appropriate are:

- The caregiver is too frail or otherwise unable to provide all of the needed personal care.
- There is no unpaid caregiver available and the beneficiary wishes to remain at home.
- The beneficiary is new to hospice but has been receiving personal care services through Home Help.

If hospice services duplicate or replace personal care services, payment is not approved for Home Help.

The hospice must contact the beneficiary's MDHHS adult services worker or ask for the assignment of an adult services worker if the beneficiary does not already have one. The adult services worker determines which personal care services may be provided in addition to hospice care. This determination may require the hospice to submit a POC for the worker's review.

SECTION 7 - BILLING & REIMBURSEMENT

7.1 MEDICARE/MEDICAID BENEFICIARIES

If a beneficiary is dually enrolled in Medicare and Medicaid, they must receive hospice coverage under the Medicare benefit. (Medicaid is the payer of last resort.) If the beneficiary resides in a NF, Medicare may pay hospice services, with NF room and board paid for by Medicaid. When a beneficiary is receiving services through the Medicare hospice benefit, Medicaid does not pay for curative or duplicative services.

The hospice provider must complete the admission in CHAMPS prior to submission of a Medicaid claim (i.e., coinsurance, deductibles, and room and board in the NF or hospice-owned NF). The hospice provider must also complete the beneficiary's discharge (voluntary or involuntary) or upon notification of the beneficiary's demise. (Refer to other applicable Sections for details regarding admission and discharge guidelines.)

If the hospice benefit is revoked under Medicare, the beneficiary cannot use the Medicaid hospice benefit as a replacement. Hospices should carefully explain this situation to the dually eligible beneficiary, especially during the fourth Medicare benefit period.* However, if the dually eligible beneficiary is no longer appropriate for hospice care and is discharged as a hospice beneficiary, that beneficiary is eligible for re-admittance with the hospice for the Medicaid benefit period if they become eligible for hospice again.

7.2 MEDICAID HEALTH PLAN ENROLLEES

Hospice services are included in the Medicaid Health Plan (MHP) covered services package for Medicaid enrollees. If the terminally ill enrollee requests and meets the criteria for hospice services, the MHP must cover the requested hospice services. If the terminally ill enrollee does not request hospice services, the MHP may provide its own array of services for the terminally ill. If the beneficiary is enrolled in a MHP (eligibility response indicates the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC), the hospice must contact the MHP immediately to receive prior authorization (PA) from the MHP before furnishing services. The MHP may require its enrollees to receive hospice services through a contracted hospice with which they have made arrangements. MHPs are responsible for the hospice care arrangement and payment if the eligibility response indicates a Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC for the beneficiary.

If a fee-for-service (FFS) Medicaid beneficiary is automatically enrolled in a MHP while receiving hospice care, the beneficiary or their representative should contact the MDHHS Hospice Enrollment Coordinator if they wish to continue receiving services from their current hospice provider. (Refer to the Directory Appendix for contact information.) The Hospice Enrollment Coordinator initiates the process of disenrollment from the MHP. It is not the intent of MDHHS to disrupt a hospice beneficiary's care through automatic enrollment in a MHP. If the beneficiary is subsequently discharged from hospice care, the beneficiary may be offered the opportunity to join a MHP.

* The fourth Medicare benefit period is the subsequent extension period during the beneficiary's lifetime that occurs after the first two 90-day periods, and subsequent 60-day period, have been utilized.

If the MHP enrollee requires hospice services in a NF or hospice-owned NF, the MHP pays a negotiated rate for room and board in addition to the payment for the hospice services. The hospice must contact the MHP prior to admitting the beneficiary for hospice services to request authorization by the MHP.

7.3 Reimbursement

MDHHS employs the following standards when reimbursing for hospice care:

7.3.A. Rate Methodology

MDHHS uses the Medicaid hospice payment base rates established and provided by CMS and applies the appropriate local wage adjustors provided by CMS for the four categories of hospice care in each Core Based Statistical Area (CBSA). Effective for dates of service on or after January 1, 2016, a severity intensity add-on (SIA) rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by an RN and/or Social Worker when the beneficiary is receiving routine home care. (This payment is made in addition to the routine home care rate for the day.) However, the total of combined time rendered by an RN and Social Worker will not be reimbursed for more than four hours a day. Medicaid Fee for Service hospice providers who have not submitted required quality data to the Centers for Medicare & Medicaid Services (CMS) in compliance with the Hospice Quality Reporting Program (HQRP) will receive reduced reimbursement. Medicaid publishes and implements rate updates each fiscal year or when directed by CMS. (Refer to the MDHHS Hospice Reimbursement Rates on the MDHHS website.)

7.3.B. Coinsurance

When a Medicaid beneficiary is receiving hospice services under Medicare, the hospice may bill Medicaid for the coinsurance, as well as room and board, if the beneficiary resides in a NF or hospice-owned NF. Coinsurance and/or room and board cannot be billed to a Medicaid beneficiary, their family, or their representative.

7.3.C. Date of Discharge

Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another as long as services were provided by both agencies. (This will be randomly verified by post payment audit and as indicated.) If the beneficiary has hospice as of 12:01 am, the hospice is responsible for the payment of services provided to the beneficiary until midnight. The hospice will continue, for payment purposes, as the primary provider for the full day of discharge.

Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered.

7.3.D. Physician or NPP Services

Reimbursement for administrative duties performed by the Medical Director is included in normal hospice rates. Direct patient care provided by the Medical Director, hospice-employed physician, NPP, or consulting physician may be billed by the hospice and is separately reimbursable based on the lesser of Medicaid's maximum allowable amount for the service or the charge. Claims must reflect the Healthcare Common Procedure Coding System (HCPCS) procedure codes for the physician's direct patient care.

7.3.E. Patient-Pay Amount

If the Medicaid beneficiary residing in a NF has a patient-pay amount (PPA), the hospice must collect that amount each month and apply it toward the beneficiary's Medicaid covered services, and non-covered services as allowed by Medicaid. While the hospice is responsible for collecting the PPA, this duty may be delegated to the NF (via contract with the hospice) as long as the amount is applied to the room and board bill. The PPA must be exhausted each month (even if services do not span the entire month) before any Medicaid payment can be made. Whenever the hospice collects a PPA, a receipt must be given to the beneficiary (or family).

The provider must bill Medicaid for services rendered even if the PPA exceeds the Medicaid reimbursement rate resulting in a zero dollar payment. The Hospice Claim Completion Section of the Billing & Reimbursement for Institutional Providers Chapter contains examples of the application of the PPA.

CHAMPS handles the PPA in the following manner: When a beneficiary has a monthly PPA and a corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS, resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the location of the beneficiary at the first of the month. This will prevent the PPA from being deducted from the wrong claim.

Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.

7.3.F. Payment for Noncovered Services

For necessary medical or remedial care recognized under State law but not covered by Medicaid, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to access their patient-pay amount to pay for these services as allowed by Medicaid. If Medicare covers the beneficiary's need for medical services, then Medicaid continues to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

7.3.G. Medicaid Deductible

The hospice must verify eligibility before providing hospice services to the beneficiary in a home setting. (Refer to the Beneficiary Eligibility chapter for additional information.) If the eligibility response indicates a Benefit Plan ID of Spend-down, the hospice should ask the beneficiary or their responsible person for a copy of the MDHHS letter sent the first of each month which indicates the dollar amount the beneficiary must spend before becoming Medicaid-eligible for services. Medicaid may not be billed until the Medicaid deductible obligation is met and the eligibility response indicates a Benefit Plan ID of MA or MA-HMP.

7.3.H. Room and Board to Nursing Facilities

When Medicaid reimburses the hospice for room and board in a NF, the beneficiary must be placed in a bed certified by Medicaid (i.e., a Medicare/Medicaid certified bed or one certified Medicaid-only). If the beneficiary is not placed in a bed certified for Medicaid, MDHHS does not pay for any services. Except for State Veterans' Homes, MDHHS pays the hospice 95 percent of the individual or specific facility's Medicaid rate for room and board plus 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate. Hospice reimbursement to the NF for room and board must be outlined in the contract established between the hospice and the NF.

- **Holding a Bed (Hospital Leave and Therapeutic Leave).** For NF beneficiaries on hospice, Medicaid reimburses the hospice for holding a NF bed as indicated below.

  Hospice reimbursement to the NF for bed holds must be outlined in the contract between the NF and the hospice.

  Family members/responsible parties for the hospice/NF beneficiary must be informed of the bed hold and readmission policy of the NF. If the beneficiary refuses to have a family member/responsible party notified, this must be documented in the beneficiary's medical record.

- **Hospital Leave Days.** For Hospital Leave Days, Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.5 percent occupancy may round up to 98 percent. Medicaid reimburses during a beneficiary's temporary absence (up to 10 days) from the NF for admission to the hospital for emergency medical treatment as documented by the attending physician in the beneficiary's medical record. The facility must hold the bed, and the hospice may bill Medicaid, if the attending physician documents a reasonable expectation at the point of admission to the hospital that the beneficiary will return to the NF by the end of the 10th day.

  The beneficiary must return to the NF within 10 days for the hospice to bill for hospital leave days. If the beneficiary is in the hospital for more than 10 days, the NF is released from its obligation to hold the bed and the hospice cannot bill Medicaid for any leave days. Reimbursement to the hospice is at 100 percent of the class wide NF hospital leave day rate. This rate, determined annually by MDHHS, is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

If the beneficiary is expected to be in the hospital for 10 days or fewer, and dies while in the hospital, the hospice may bill Medicaid for the hospital leave days up to the day before the beneficiary died.

If the beneficiary returns to the NF under Medicare coverage and still elects hospice care, the hospice may bill Medicaid for the hospital leave days if the emergency hospitalization was for no more than 10 consecutive days.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The hospice/NF should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. CHAMPS automatically deducts the patient-pay amount and reimburses the provider for the balance. If the hospice bills Medicaid for hospital leave days that occur at the beginning of the month, then the hospice should collect the patient-pay amount as usual. The hospice should charge the amount against the patient-pay that Medicaid pays for that day. For example, if a beneficiary has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay totals no more than 10 consecutive days), the hospice should collect the patient-pay amount from the beneficiary and then submit a Medicaid claim. Medicaid reimburses the hospice for the hospital leave day per diem rate, minus the patient-pay amount.

There is no annual limit to the number of hospital leave days per beneficiary that may be billed to Medicaid as long as there are no more than 10 consecutive leave days per hospital stay.

- **Therapeutic Leave Days.** If the beneficiary has a temporary absence from the NF for therapeutic reasons approved by the attending physician or NPP, the hospice may be reimbursed by Medicaid to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for nonmedical reasons such as overnight stays with friends/relatives, Make-a-Wish Foundation trips, etc. The beneficiary's POC must provide for such absences. There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period. If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date they left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

  Reimbursement is at 95 percent of the individual or specific NF's daily per diem rate, just as the customary room and board rate is reimbursed.

- **Hospice Revocation or Decertification.** If a Medicaid hospice beneficiary who resides in a NF revokes their hospice services or is deemed no longer certifiable for the Medicaid hospice benefit, the hospice may bill for services on the day of revocation/ decertification, as well as the hospice/NF room and board, as long as the beneficiary is in the facility at the midnight census.

- **Ventilator Dependent Care Unit (VDCU) or Complex Care Case.** Refer to the Place of Service subsection of this chapter for information regarding payment of room and board for these hospice beneficiaries.

- **State Veterans' Homes.** MDHHS pays the hospice 100 percent of the beneficiary-specific Patient Driven Payment Model (PDPM) Medicaid rate for room and board in a State Veterans' Home, and payments will be made through gross adjustments. In addition to standard billing practices, hospice providers must follow the State Veterans'

Homes billing policy found in the Billing & Reimbursement for Institutional Providers chapter. The hospice must submit a separate claim from other services for the room and board provided in a State Veterans' Home. Hospice reimbursement for room and board must be outlined in the contract established between the hospice and the State Veterans' Home.

7.3.I. Adult Foster Care Facilities/Home for the Aged Facilities

Medicaid does not reimburse for room and board in these settings. Reimbursement is made directly to the facility provider in the normal manner (i.e., Supplemental Security Income, Personal Care/Supplemental Payment). This payment is made in full. The AFC or HFA cannot seek additional restitution from the beneficiary or the hospice provider.

7.3.J. Boarding Homes

Medicaid does not reimburse for room and board in these settings.

7.3.K. Assisted Living Facility

Medicaid does not reimburse for room and board in these settings.

7.4 Reimbursement Limits

Medicaid does not apply an aggregate dollar capitation. (The Medicare program establishes the maximum total dollar amount per year that Medicare pays for hospice services. Medicaid does not apply this policy to beneficiaries receiving hospice care.)

Medicaid applies the same number of inpatient respite days as Medicare (i.e., no more than five consecutive days are allowed). If more than five consecutive days are billed, the number is reduced to five days, and the excess days must be billed as routine care by the hospice.

Reimbursement for routine, non-emergent transportation is included in the per diem (room and board amount) negotiated between the hospice and the NF.

HOSPITAL

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SECTION 1 – GENERAL INFORMATION [CHANGE MADE 4/1/2025]

This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Health and Human Services (MDHHS). The attending provider is the individual who has the primary responsibility for the treatment and care of the beneficiary. Depending on the setting and professional licensure regulations, the specific provider type can vary. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims. **(correction made 4/1/2025)**

The appropriate revenue code from the National Uniform Billing Committee (NUBC) and/or State Uniform Billing Committee (SUBC) manuals must be used on each claim line for all institutional claims. If a procedure code is required, a Healthcare Common Procedure Coding System (HCPCS) code(s) must be used.

Prior authorization (PA) information in this chapter pertains to FFS Medicaid and FFS Children's Special Health Care Services (CSHCS) only. If the beneficiary is enrolled in a MHP, the hospital must obtain any required PA from the beneficiary's MHP when providing services.

1.1 INPATIENT HOSPITAL

An inpatient hospital is defined as a facility, other than psychiatric, which primarily provides medically necessary diagnostic, therapeutic (both surgical and nonsurgical) or rehabilitation services to inpatients. Services provided to inpatients include bed and board; nursing and other related services; use of facility; drugs and biologicals; supplies, appliances and equipment; diagnostic, therapeutic and ancillary services; and medical or surgical services. Services of professionals (e.g., physician, oral-maxillofacial surgeon, dental, podiatric, optometric) are not included and must be billed separately. Inpatient hospital services are:

- Ordinarily furnished in a facility for the care and treatment of inpatients.
- Furnished under the direction of a physician (MD or DO), podiatrist, oral/maxillofacial surgeon, certified nurse midwife, or a dentist.
- Furnished in a facility that is:
  - Maintained primarily for the care and treatment of inpatients with disorders other than mental diseases;
  - Licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
  - Medicare-certified to provide inpatient services.

An inpatient is an individual who has been admitted to a hospital for bed occupancy with the expectation that they will remain at least overnight, even when it later develops that they can be discharged or is transferred to another hospital and does not use the bed overnight. Days of care provided to a beneficiary are in units of full days, beginning at midnight and ending 24 hours later. Medicaid covers

the day of admission but not the day of discharge. If the day of admission and the day of discharge are the same, the day is considered an admission day and counts as one inpatient day.

1.2 Outpatient Hospital

An outpatient hospital (OPH) is defined as a portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization. Outpatient hospital services are:

- Furnished under the direction of the provider with the primary responsibility for the treatment and care of the beneficiary in the outpatient setting. The provider type varies according to the service provided. A complete list of allowed attending providers for outpatient services can be found on the MDHHS website. Refer to the Directory Appendix for website information.
- Furnished in a facility that is certified as a provider, or as having provider-based status, by Medicare.

To facilitate coordination of benefits, MDHHS follows Medicare's coverage policies as closely as possible and appropriate. Differences in coverage policy are described in this chapter.

1.3 Third Party Liability

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits chapter for additional information.)

1.3.A. Medicare-Related Services

MDHHS reimburses for Medicare-covered services up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. Medicare benefits must be used prior to billing MDHHS or any Medicaid-capitated plan (MHP, PIHP/CMHSP) for any portion of the claim.

MDHHS reimburses Medicare coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims, even if Medicaid does not normally cover the service. Lifetime Reserve Days (LRD) must be used, if available.

1.3.B. Other Insurance

Medicaid and CSHCS beneficiaries may have insurance coverage, either traditional health insurance or a Health Maintenance Organization (HMO), through private and/or employer-based commercial policies. The other insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, PA requirements, provider qualifications, and receiving services through the insurer's provider network. MDHHS does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

Medicaid covers the appropriate copay and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has

negotiated a rate for a service that is lower than the Medicaid fee screen, MDHHS cannot be billed more than the negotiated rate. MDHHS reimburses Medicaid-covered services that are not included in the primary insurer's plan up to the Medicaid fee screen if all Medicaid coverage rules have been followed. If a beneficiary is enrolled in a MHP or is receiving services through a PIHP/CMHSP, the MHP/PIHP/CMHSP is responsible for payment.

1.4 COPAYMENTS

Copayments may be required for inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department for beneficiaries age 21 years and older. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Copayments for the first day of an inpatient stay apply to the DRG or first day per diem payment. A copay will not be applied to emergent admissions, transfers between acute care hospitals, from acute care to rehab, or to readmits within 15 days for the same DRG/diagnosis.

Federal regulations at 42 CFR §447.54 specify the cost-sharing requirements for services provided in a hospital emergency department. To impose cost sharing for non-emergency services provided in a hospital emergency department, the hospital must:

- Perform appropriate medical screening under 42 CFR §489.24 Subpart G to determine the individual does not need emergency services.
- Before providing nonemergency services:
  - inform the individual of the amount of cost sharing responsibility for non-emergency service(s);
  - provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
  - determine that the alternative provider can provide services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the person is otherwise exempt from cost sharing; and
  - provide a referral to coordinate scheduling for treatment with the alternative provider.

Hospitals providing emergency department services are expected to develop cost sharing policies and procedures consistent with the federal requirement.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.5 Miscellaneous

1.5.A. Abuse

Providers with reasonable cause to suspect that a child or vulnerable adult may have been abused or neglected are required by law to immediately report it to the appropriate Protective Services Unit of the local MDHHS office. Inpatient hospital stays for suspected abuse or neglect are covered if the attending provider determines the beneficiary requires further assessment and treatment. Inpatient stays for the sole purpose of custodial or protective care are not a covered benefit.

1.5.B. Administrative Services

Interns, resident physicians, dentists, or medical staff who are functioning in an administrative, teaching, or learning capacity for the hospital cannot bill MDHHS for their professional services as these costs are included in the hospital's Graduate Medical Education (GME) payments. This includes physician-owners or other staff paid by the hospital. Staff meetings for any purpose are not reimbursable. Reimbursement for administrative services is included in the Diagnosis Related Group (DRG) payment, as well as the MDHHS Outpatient Prospective Payment System (OPPS).

1.5.C. Communicable Disease

Cases of communicable disease, such as tuberculosis, hepatitis, meningitis, and enteric disease, must be reported to the local health department (LHD). For additional information, contact the LHD.

1.5.D. Educational Costs for Professional Education

Payments for educational costs are made directly to hospitals for health professional education in both the inpatient and outpatient hospital setting according to the requirements and formulas in the Hospital Reimbursement Appendix of this chapter.

1.5.E. Hospital-Based Provider

A hospital-based provider (HBP) is defined as a hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), physician's assistant (PA), advanced practice registered nurse (APRN) [including certified nurse practitioner (NP), certified clinical nurse specialist (CNS) or certified nurse midwife (CNM)], dentist, podiatrist, or optometrist. HBPs must be enrolled separately as Medicaid providers and bill MDHHS directly using their own provider NPI number for any covered professional service(s) that they provide. (Refer to the appropriate provider-specific chapter and the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5.F. Hospital Personnel Providing Ambulance Transport Assistance

Only enrolled ambulance, including hospital-owned ambulance service, providers may provide ambulance services. MDHHS does not reimburse hospitals for staff personnel who assist with an ambulance transport. The cost of all hospital personnel is considered part of the normal hospital operation (included in the cost center) and may not be billed to MDHHS or to the beneficiary.

1.5.G. Pharmacy

Pharmaceutical products (drugs and biologicals) provided to inpatients are covered as a component of the inpatient DRG and are not reimbursed separately.

MDHHS follows Medicare's coverage policies related to outpatient hospital pharmacy services.

Take-home drugs require a prescription or prescription order that includes the prescriber's NPI and are covered only when provided by a Medicaid-enrolled pharmacy. All prescriptions or prescription orders must comply with state and federal laws.

(Refer to the Pharmacy Chapter of this manual for additional information.)

An emergency room practitioner must report their individual NPI with a prescription order. Each practitioner at a teaching hospital must report their individual NPI with a prescription order that is submitted to the dispensing pharmacy.

1.5.H. Outpatient Ambulatory Surgery and Emergency Services Provided on Date of an Inpatient Hospital Admission

Outpatient ambulatory surgery and ED services provided at the same hospital resulting in an inpatient admission must be included as part of the inpatient stay and are reimbursed as part of the DRG payment. Charges for emergency services or ambulatory surgery that result in admission must be reflected on the inpatient claim for that episode of care. The date of admission should be reported as the date the physician wrote the order to admit the beneficiary.

1.5.I. Services That Must be Billed by Other Providers

The following services may not be provided and billed as an outpatient hospital service. These services may be provided and billed by the appropriate enrolled provider:

- Advanced Practice Registered Nurse (APRN)*
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor
- Dentist
- Durable medical equipment
- Hearing aids
- Home health
- Medical supplies (take-home)
- Optical
- Oxygen (take-home)
- Orthotics
- Pharmacy (take-home)
- Physician
- Physician Assistant*
- Podiatrist
- Prosthetics
- Shoes

* If not an employee of the hospital.

1.5.J. Technician Calls

Overtime or holiday pay to technicians who are required to be at the hospital outside of their normal work hours are not separately billable to beneficiaries or to Medicaid. These charges are included in the hospital's standard charge structure.

SECTION 2 - PRIOR AUTHORIZATION [CHANGE MADE 7/1/2025]

MDHHS requires prior authorization (PA) for certain procedures to validate the medical need for the service. The following chart, intended for reference only, indicates services provided in the hospital setting that require PA, who must obtain it, how to obtain the PA, and the documentation required when the claim is submitted. Hospital services requiring PA include:

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Cosmetic Surgery	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	Prior Authorization (PA) Number
Freestanding Rehabilitation	Hospital	MDHHS Program Review Division (PRD)	Billing Authorization Number
Long Term Acute Care Hospital (LTACH)	Hospital	MDHHS PRD	Billing Authorization Number
Inpatient Psychiatric Admissions/Continued Stay	Hospital or Attending Physician	Phone call to local PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDHHS
* Outpatient Occupational Therapy (OT) (after the initial 12 months of treatment or 144 units)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Physical Therapy (PT) (after the initial 12 months of treatment or 144 units)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Outpatient Speech-Language Pathology (after the initial 12 months of treatment or 36 visits)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
Outpatient Psychiatric Partial Hospitalization	Hospital	Phone call to PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDHHS
* Services for Weight Reduction (e.g., Surgery)	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	PA Number
* Organ Transplants	Attending Physician	Contact the Program Review Division	PA Number
* Pediatric Multi-Channel Recording (if more than two per year considered medically necessary)	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	PA Number

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Off Label Use of Non-Protected Drug Classes **(revised per bulletin MMP 25-12)**	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B) **(revised 7/1/2025)**	PA number
Laboratory Genetic or Molecular Testing	Hospital	Genetic and Molecular Laboratory Test Authorization Request (MSA-2081)	PA number
*If the beneficiary is enrolled in a MHP, providers must contact the individual MHP to verify PA requirements.			

PA does not guarantee payment or beneficiary eligibility. The provider must check the beneficiary's Medicaid eligibility prior to rendering services. (Refer to the General Information for Providers and the Beneficiary Eligibility Chapters of this manual for additional information.)

PA is not required if the beneficiary is receiving Medicare benefits for a Medicare-approved service.

2.1 Inpatient Hospital Authorization Requirements

The information in this section applies to instate and borderland hospitals. Information regarding out-of-state hospital authorization requirements can be found in the Out-of-State/Beyond Borderland Providers subsection of the General Information for Providers chapter.

All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. In the event that an inpatient stay is deemed medically inappropriate or unnecessary, either through a pre-payment predictive modeling review or a post-payment audit, providers are allowed to submit an outpatient claim for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the MDHHS PRD. The physician/dentist should refer to the Prior Authorization Certification Evaluation Review (PACER) subsection of this chapter for specific requirements.

Medically inappropriate or unnecessary inpatient admissions may be resubmitted as outpatient claims for all outpatient services and any inpatient ancillary services performed during the inpatient stay. For claims with dates of discharge on or after October 1, 2014, when an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Examples of services related to medically inappropriate or unnecessary inpatient admission include:

- all elective admissions, readmissions, and transfers that are not authorized through the PACER system;
- admissions or readmissions which have been inappropriately identified as emergent/urgent;

- selected ambulatory surgeries inappropriately performed on an inpatient basis; and
- any other inpatient admission determined to have not been medically necessary.

Medicaid does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), and diagnostic x-rays
- Observation
- Occupational Therapy (OT)
- Patient education
- Physical Therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction or weight control (unless prior authorized)

If Medicaid does not cover the services of the physician/dentist or hospital, the physician/dentist or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representative.

2.1.A. Prior Authorization Certification Evaluation Review (PACER)

Elective admissions, all readmissions within 15 days of discharge, continued stays (when appropriate), and all transfers for surgical or medical inpatient hospital services to and from any in-state or borderland hospital enrolled in the Medicaid program require authorization through MDHHS PRD. This includes transfers between an acute care hospital, an enrolled distinct part rehabilitation unit of the same hospital, or a Long Term Acute Care Hospital (LTACH). Authorization requirements for out-of-state/beyond borderland hospitals can be found in the Out-of-State/Beyond Borderland Providers subsection of the General Information for Providers chapter. All cases are screened using industry standard evidence-based care guidelines and the clinical judgment of the review analyst and/or physician.

MDHHS PRD performs medical/surgical and rehabilitation admission, readmission, and transfer reviews through the PACER system and assigns PACER numbers.

The attending/admitting physician/dentist or representative is responsible for obtaining the PACER number before admitting, readmitting, or transferring the beneficiary, with exceptions as noted below. (Refer to the Directory Appendix for PACER authorization contact information.)

The physician/dentist is responsible for providing the PACER number to the admitting hospital. The PACER number is issued on the day that the admission is approved by the MDHHS PRD. This number is valid for the entire medical or surgical admission unless otherwise noted in this section. PACER authorization must be requested prior to the admission of the beneficiary.

Physicians/dentists are asked to provide the procedure code(s) when a surgical admission/readmission is requested.

Authorization through MDHHS PRD for the hospital admission does not remove the need for prior authorization (PA) required by Medicaid for specific services. The PA for the service must be obtained before MDHHS PRD authorization is requested.

NOTE: Do not report the PACER number on the professional claim.

Approval of an admission only confirms the need for services to be provided on an inpatient hospital basis. Payment for the admission is subject to eligibility requirements, readmission, and third party liability (TPL) reimbursement policy, along with any pre- and post-payment determinations of medical necessity.

If an admission, readmission, transfer, or continued stay is not approved, MDHHS does not reimburse for services rendered.

Reconsiderations	The attending physician/dentist or the hospital may request reconsideration of the adverse determination by MDHHS PRD regarding the need for admission, readmission, transfer, or continued stay. This reconsideration right applies regardless of the current hospitalization status of the beneficiary. Reconsiderations must be requested within three business days of the adverse determination. (Refer to the Directory Appendix for MDHHS PRD contact information.) If requested by MDHHS PRD, the provider must provide written documentation. A decision will be made by MDHHS within three (3) business days of receipt of the documentation. If the initial adverse determination is overturned, the adverse determination is considered null and void. If the initial adverse determination is upheld or is modified in such a manner that some portion of the hospital care is not authorized, the hospital is liable for the cost of care provided from the date of the initial determination, unless this determination is overturned in the Medicaid appeals process.
Technical Denials	If the provider fails to request a PACER number on a timely basis, the provider should make this request as soon as the omission is noted. When the provider contacts MDHHS PRD by telephone with an untimely request, the review analyst directs the provider to the appropriate form to complete, explaining the circumstances of the untimely request. If upon review of this written documentation the untimeliness is waived, the case is reviewed for medical necessity and the appropriateness of the admission, readmission, or transfer. If approved, MDHHS issues a PACER number. If the untimeliness issue is not approved, the attending physician/dentist and the hospital are notified in writing within three (3) business days of the decision. The physician/dentist or hospital may file an appeal through the MDHHS appeals process.

Continued Stay Denials	If MDHHS PRD does not authorize the admission or the continued stay for an admission and the beneficiary remains in the hospital for one or more days after Medicaid payment is not authorized, the hospital is at risk of Medicaid nonpayment for those days. Following discharge, the provider may request retrospective review by MDHHS, regardless of whether reconsideration was requested on the case, in writing within 30 calendar days of the discharge from the hospital. A copy of the medical record must accompany the retrospective review request. Retrospective review is conducted for only those days that were not authorized during the telephone review. MDHHS informs the provider, in writing, of the decision within 14 business days of the receipt of the request and documentation. If some or all of the previously nonauthorized days are approved, a new PACER number is issued and included in the notification of the decision. If the initial adverse determination is upheld, the notification includes the previously issued PACER number. If the provider is dissatisfied with the decision, the decision may be appealed through the MDHHS appeals process. The hospital may bill Medicaid only for the days authorized by MDHHS PRD. If MDHHS has made an adverse determination and issued a PACER number(s), the hospital may submit a claim with the PACER number(s) for only the authorized days while the case is in the reconsideration, retrospective review, or formal appeals process. Submission of such a claim does not imply acceptance of the determination.

2.1.A.1. Admissions/Readmissions/Transfers that Require a PACER Number

The following require a PACER number:

- All elective admissions.
- All readmissions within 15 days of discharge (including newborns). [NOTE: If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim. No PACER number is issued for continuation of care.]
- All transfers for medical/surgical services to and from any hospital enrolled in the Medicaid program (including newborns).
- Transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital.
- Transfer to an LTACH or admission from an LTACH to an acute care hospital.
- Authorization of continued stays in freestanding and distinct part rehabilitation units.

NOTE: If a newborn does not yet have a Medicaid ID number and a transfer or readmission occurs within 15 days, providers must request a retroactive PACER number when a newborn Medicaid ID number is issued.

2.1.A.2. Admissions/Readmissions/Transfers that Do Not Require a PACER Number

The following do **not** require a PACER number:

- Emergent/urgent inpatient hospital admissions. (All transfers and 15-day readmissions to the same or a different hospital do require PACER through MDHHS PRD.)
- All admissions and transfers to distinct-part psychiatric units or freestanding psychiatric hospitals and all continued stays in a psychiatric unit/hospital. (Authorization must be obtained through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).)
- Obstetrical patients admitted for any delivery.
- Newborns admitted following delivery and newborns delivered within an emergency department and subsequently admitted to another facility.
- Admissions of beneficiaries who are eligible for CSHCS only.
- Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP). (Authorization must be obtained through the MHP.)
- When a beneficiary is admitted to a hospital that is not enrolled with the Michigan Medicaid Program.
- When a beneficiary becomes Medicaid eligible after the admission, readmission, transfer, or certification review period. (When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.)
- Medicare Part A beneficiaries.
- Commercial insurance coverage for admissions, readmissions, transfers, or continued stays.

2.1.A.3. PACER Readmissions

To be separately reimbursable, all readmissions (whether to the same or a different hospital) for hospital services must be prior authorized through MDHHS. The request for a PACER number for an elective readmission, whether to the same or a different hospital, must be made prior to readmission. The request for a PACER number for an emergent/urgent readmission to the same hospital must be made by the next business day following the readmission. The request for a PACER number for an emergent/urgent readmission to a different hospital must be made prior to the beneficiary's discharge from a transferring hospital. Medicaid defines readmission, for purposes of review, as any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or a different hospital.

If the hospital intends to combine an admission and a readmission into a single episode for DRG payment purposes, MDHHS PRD should not be contacted for a separate PACER number for the readmission.

Before contacting MDHHS, the provider should assemble as much information as possible regarding the medical condition of the beneficiary upon the first discharge and at the time of the readmission. When contacted for a PACER number, MDHHS either:

- Agrees that the original admission and the readmission are unrelated, as well as medically necessary, and issues a PACER number so that the stays may be billed and paid separately by the same hospital;
- Authorizes a readmission to a different hospital as medically necessary and issues a PACER number;
- Asks the caller to obtain additional information and call back no later than the next business day; or
- Questions the relatedness of two stays at the same hospital or the medical necessity for the readmission and may approve and issue a PACER number or deny the request.

If a PACER number is not provided for a readmission due to relatedness (required as a consequence of the original admission), the hospital must combine the two stays into a single episode for DRG payment purposes (using the Leave of Absence revenue code 0180 for the time between discharge and readmission), or request reconsideration of the MDHHS decision within three business days. If the initial admission has already been billed, the hospital must submit a claim replacement to combine the two stays.

If it is determined a readmission is medically unnecessary, the hospital may only bill for the first admission.

2.1.A.4. PACER TRANSFERS

If a beneficiary needs to be transferred, authorization for the transfer must be obtained through MDHHS PRD. Authorization for a transfer is granted only if the transfer is medically necessary and the care or treatment is not available at the transferring hospital. Additionally, authorization may be granted if the beneficiary is a newborn returning to the originating hospital. Transfers for convenience are not considered. Transfers include the following situations:

- Transfer from one inpatient hospital to another.
- Transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct-part rehabilitation unit).

Transfer to a distinct-part psychiatric unit of a general hospital or a freestanding psychiatric hospital is subject to review and approval by the beneficiary's PIHP/CMHSP. Do not contact MDHHS PRD for a PACER number. (Authorization must be obtained through the local PIHP/CMHSP.)

The following describes the appropriate requestor and timeframes for transfer authorization:

- Elective transfers – the transferring physician/dentist or designee must obtain authorization prior to transfer.

- Emergent/urgent transfers – the authorization must be obtained by the transferring physician/dentist no later than the next business day, or by the receiving physician/dentist or hospital before discharge.

If the transfer is approved, a PACER number is issued. The receiving hospital must use this PACER number when billing. The transferring hospital continues to use the original PACER number if a PACER number was required for the admission.

2.1.B. Admissions and Continued Stays for Distinct Part Rehabilitation Units and Freestanding Rehabilitation Hospitals

Admissions and continued stays require authorization through the MDHHS PRD. Continued stays beyond 30 days require additional inpatient authorization.

- The hospital must call MDHHS between the 27th and 30th day of the stay if the stay is expected to exceed 30 days. If the continued stay is certified, a PACER number is issued. The PACER number must appear on the hospital's claim if the stay is greater than 30 days but less than 60 days.
- The hospital must call MDHHS between the 57th and 60th day of the stay if the stay is expected to exceed 60 days. If the continued stay is approved, the hospital is given another PACER number. This PACER number must appear on the hospital's claim if the stay is greater than 60 days.

2.1.C. Admission/Transfer for Long-Term Acute Care Hospital (LTACH)

A transfer or admission from an acute care hospital or inpatient rehabilitation unit to an LTACH requires a PACER number.

- The acute care hospital or inpatient rehabilitation unit is responsible for obtaining the PACER number before the discharge to an LTACH.
- If the LTACH admission meets InterQual LTACH criteria, a PACER number will be issued for no more than 30 days.
- Subsequent prior authorization and continued stay approvals must be obtained by the LTACH.
- A transfer from the LTACH to an acute care hospital will require an inpatient PACER number.

2.2 Termination of Benefits

The hospital's Utilization Review Committee may issue a notice of noncoverage to the beneficiary if it determines that the admission or continued stay in the hospital is not medically necessary; a copy of the notice should be sent to the MDHHS PRD – PACER Program. (Refer to the Directory Appendix for contact information.) The notice should be substantially similar to the sample letters contained in the Forms Appendix of this manual.

If issued, the notice is the responsibility of the hospital's Utilization Review Committee and is not related to any decision that may have been rendered by MDHHS on the case. The decision must be based on the findings of the Utilization Review Committee and not on the determination of MDHHS.

If the beneficiary or beneficiary's representative disagrees with the notice, the beneficiary or representative may contact MDHHS to appeal the decision. If MDHHS previously issued an adverse determination for the period of hospitalization covered by the notice, MDHHS informs the beneficiary of concurrence with the hospital decision. If MDHHS did not previously issue an adverse determination for the period, a review of the medical record is conducted. MDHHS will contact the hospital to obtain a copy of the medical record, review the medical necessity of the admission or continued stay, and issue a decision within three business days of receiving the hospital's Utilization Review Committee notice of noncoverage and the beneficiary's supporting medical records.

As with any benefit denial, the beneficiary or beneficiary's representative may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDHHS or a MDHHS contracted agency (i.e., any agency, organization, or health plan contracted by MDHHS) that either determines eligibility for a MDHHS program, or delivers a service provided under a MDHHS program to a beneficiary, patient or resident. MOAHR issues timely, clear, concise and legally accurate hearing decisions and orders. The MOAHR Policy and Procedures Manual explains the process by which each different type of case is brought to completion. The MOAHR manual is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 3 – COVERED SERVICES

Hospital services requiring additional information are listed below in alphabetical order. Some services have coverage limitations and/or PA requirements.

For outpatient hospital services, MDHHS follows Medicare's coverage policies as closely as possible and appropriate. Differences or clarifications of coverage are described in this section.

3.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions.

Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure.

The medical record must include a complete beneficiary history, including the medical condition that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

3.2 ACCOMMODATIONS

Medicaid covers private, semi-private, three-bed, or four-bed accommodations. The hospital's inpatient accommodation rate includes all charges associated with routine services (e.g., linens, nursing services, etc.) rendered during the inpatient stay. All dietary services, including special diets, are included in the accommodation rate and are not allowable under any other cost center.

3.2.A. Intensive Care

Intensive care provided in an intensive care unit(s) is covered for the treatment of critically ill beneficiaries. Neonatal intensive care unit accommodations may be billed only if medically necessary, the infant is treated in this setting, and the neonatal unit has been approved by MDHHS to provide this level of service.

3.3 Ambulance

MDHHS coverage policies related to hospital-owned ambulance services are contained in the Ambulance Chapter of this manual.

3.4 Anesthesia

Medicaid policy coverage includes anesthesia services when provided by qualified practitioners in conjunction with surgical services or other procedures when medically necessary.

Medicaid does not cover anesthesia services related to the treatment of infertility.

Physician, CRNA, or AA professional charges may not be billed on the outpatient hospital claim format. These professional charges must be billed on a CMS 1500 claim form. (Refer to the Billing & Reimbursement for Professionals and the Practitioner Chapters of this manual for additional information.)

3.5 Apheresis

MDHHS follows Medicare's coverage and guidelines for therapeutic apheresis in an outpatient hospital. Therapeutic apheresis is defined as a continuous autologous procedure and is covered as follows:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom);
- Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes;
- Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritus of cholestatic liver disease;
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome;
- Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy;

- Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome; and
- Treatment of life-threatening Systemic Lupus Erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration.

Apheresis is not a covered service when a beneficiary donates blood preoperatively and, at a later date, the blood is transfused back to the beneficiary.

3.6 Apnea Monitors

Monitors must be provided by a Durable Medical Equipment (DME)/Medical Supply provider and may be covered on a rental basis without PA for up to three months from the date of discharge from the hospital for symptomatic infants discharged on a monitor. The hospital medical record must document that the infant was discharged on a monitor. The medical supplier must also note in their records that the child was discharged on a monitor, and a hospital discharge planner arranged for the apnea monitor rental. (Refer to the Medical Supplier Chapter of this manual for additional information.)

3.7 Beneficiary Education

Beneficiary education in the inpatient setting is included in the DRG payment. Beneficiary education services are covered in an outpatient setting as follows:

3.7.A. Childbirth Education

MDHHS covers childbirth education programs for pregnant women. The prenatal care provider must make written referrals for the pregnant woman, and the program must be provided by qualified educators in a Medicaid-enrolled outpatient hospital or by a certified Maternal Infant Health Program (MIHP) provider. This service is not covered if rendered by a prenatal care provider in the office setting. MDHHS covers childbirth education (also referred to as birthing education) as a complete program. MDHHS does not separately cover on-line (a type of distance learning) education classes.

Childbirth education includes, but is not limited to, the following topics:

Pregnancy	▪ Health care during pregnancy ▪ Physical and emotional changes during pregnancy ▪ Nutrition

Labor and Delivery	▪ Signs and symptoms of labor, including information regarding pre-term labor ▪ Breathing and relaxation exercises ▪ Analgesia and anesthesia ▪ Avoiding complications ▪ Coping skills ▪ Types of deliveries ▪ Episiotomy ▪ Support techniques ▪ Hospital tour
Infant Care	▪ Preparation for breast feeding ▪ Infant feeding ▪ Immunizations ▪ Infant carseat use ▪ Parenting
Postpartum	▪ Postpartum physical and emotional changes, including depression ▪ Feelings of partner ▪ Potential stress within the family ▪ Sexual needs ▪ Exercise ▪ The importance of family planning

3.7.B. Diabetes Self-Management Education (DSME) Training Program

DSME is intended to educate beneficiaries in the successful self-management of their diabetes. MDHHS covers DSME when ordered by a physician or qualified non-physician medical practitioner responsible for the beneficiary's diabetic care and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid-enrolled outpatient hospital or Local Health Department (LHD) that meets one of the following requirements:

- Certified as a DSME program by MDHHS, Population Health Administration; or
- Association of Diabetes Care and Education Specialists (ADCES) accreditation by the Diabetes Education Accreditation Program (DEAP); or
- American Diabetes Association (ADA) recognition by the Education Recognition Program (ERP).

DSME program requirement information must be provided to MDHHS via the CHAMPS Provider Enrollment on-line system. (Refer to the Directory Appendix for contact information.) DSME services may not be rendered to eligible beneficiaries or billed for payment until the appropriate requirement information is on file and approved.

The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis in the medical record for initial and follow-up education and training. They must also document any special needs supported by medical necessity.

MDHHS aligns with Medicare's DSME training billing guidelines when possible. Medical Nutrition Therapy (MNT) is not a separately covered or reimbursed DSME Medicaid covered service.

Medicaid-enrolled DSME programs are expected to submit the MDHHS Annual Statistical Data Report following the reporting requirements located on the MDHHS website. This information is used for statewide reporting of statistical information to the Centers for Disease Control and Prevention (CDC). (Refer to the Directory Appendix for website information.)

DSME is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a provider who does not meet Michigan Medicaid DSME program requirements.

3.7.C. Kidney Disease Education (KDE) Services

MDHHS covers kidney disease education (KDE) of beneficiaries diagnosed with stage IV chronic kidney disease (CKD). If KDE is done in the outpatient hospital (OPH), only the OPH or physician (qualified person) may bill for services on the same day, same beneficiary.

MDHHS follows Medicare's coverage and reimbursement policies related to KDE.

3.8 Blood Products

MDHHS coverage aligns with Medicare OPPS coverage and billing guidelines as closely as possible for Blood Processing/Storage in an outpatient hospital. Providers must bill appropriately following the Medicare coding and reporting requirements.

3.9 Chemotherapy Treatment

MDHHS covers antineoplastic drugs. MDHHS does not cover antineoplastic agents that are investigational or experimental.

3.10 Clinic Services

Hospital Clinic services are covered if rendered in a clinic setting that is part of the licensed and Medicaid-enrolled hospital, and that satisfy Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include non-emergency outpatient services that are provided to ambulatory beneficiaries.

MDHHS covers Urgent Care Clinics (as part of the Medicaid-enrolled hospital and that satisfy Medicare requirements for provider-based status) when the services provided are specific to urgent medical care

(i.e., suturing, most fracture care) and are medically necessary for a non-life threatening condition or injury, or illness that should be treated within 24 hours.

3.11 Clinical Trials

The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are defined as any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. Routine patient costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

Refer to the Billing & Reimbursement for Institutional Providers, the Billing & Reimbursement for Professionals, and the Practitioner chapters for information related to coverage of routine patient costs furnished in connection with participation in a clinical trial.

3.12 Dental Services

Dental services are routinely rendered in the dental office unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or beneficiary.

Non-emergency routine dental treatment provided in an outpatient hospital setting is covered only under the following conditions:

- A concurrent hazardous medical condition exists;
- The nature of the procedure requires hospitalization; or
- Other factors (e.g., behavioral problems due to mental impairment) necessitate hospitalization.

Hospitals should refer to the Dental Chapter of this manual for information regarding program limitations prior to rendering services.

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service be done in the hospital setting.

3.13 Dialysis (Hemodialysis and Peritoneal Dialysis)

MDHHS coverage and reimbursement is an all-inclusive rate for emergency ESRD dialysis services and maintenance outpatient dialysis services for beneficiaries receiving hemodialysis or peritoneal dialysis. MDHHS follows the Medicare billing guidelines for hemodialysis and peritoneal dialysis for both in-person and telemedicine visits. Individual services may not be billed separately. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as:

- Oxygen;
- Filters;
- Declotting of shunts;
- Staff time to administer blood or oxygen; and
- Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrhythmics.

MDHHS reimburses the physician directly for professional services related to maintenance dialysis.

Nonroutine additional services must be billed using the appropriate supporting HCPCS code. The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDHHS does not reimburse the medical supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.

3.13.A. Dialysis Laboratory Services

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. Laboratory services included in the composite rate should be billed to the dialysis facility when performed by an outside laboratory. The dialysis facility and the outside laboratory must coordinate billing to ensure duplicate payments do not occur. A freestanding dialysis center that performs its own laboratory tests and needs to bill for services outside of those included in the composite rate must enroll with Medicaid as an independent laboratory. Freestanding dialysis centers enrolled as independent laboratories are subject to the Out of State /Beyond Borderland Provider Medicaid policy.

The following laboratory tests are considered to be a routine part of maintenance dialysis (Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis) and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated:

Per Treatment	Weekly	Monthly
▪ All hematocrit or hemoglobin tests and clotting time tests	▪ Prothrombin time for patients on anticoagulant therapy ▪ Serum Creatinine ▪ BUN	▪ CBC, including platelet count and additional indices ▪ Serum Calcium ▪ Serum Chloride ▪ Serum Potassium ▪ Serum Bicarbonate ▪ Serum Phosphorus ▪ Total Protein ▪ Serum Albumin ▪ Alkaline Phosphatase

Per Treatment	Weekly	Monthly
		▪ SGOT ▪ LDH

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the composite rate on a monthly basis include:

- Albumin
- Alkaline Phosphatase
- AST
- BUN
- Calcium Magnesium
- CO2
- Creatinine
- Dialysate Protein
- HCT
- Hgb
- LDH
- Phosphate
- Potassium
- SGOT
- Sodium
- Total Protein

Laboratory tests not listed above may be separately billed by the dialysis facility or Clinical Laboratory Improvement Amendments (CLIA)-certified lab performing the test.

3.13.B. Dialysis Self-Care Training

MDHHS reimburses for dialysis self-care training provided by outpatient dialysis clinics.

- A session is considered as one training day and a complete course is considered 10-15 sessions.
- Sessions must be documented in the beneficiary's medical record and are subject to post-payment review.

3.14 Diagnostic Testing

MDHHS policy covers and reimburses for diagnostic testing to diagnose a disease or medical condition. Outcomes must be documented in the medical record. Diagnostic testing in an inpatient hospital is included in the inpatient DRG payment. Outpatient hospitals must bill appropriately under the MDHHS OPPS.

MDHHS policy coverage does not reimburse for:

- Routine screening, such as spirometry, holter monitor, Doppler flow-study or pelvic echography.
- Testing to establish baseline values.
- Testing for the general health and wellbeing of a beneficiary.
- Any test not generally recognized as relevant to the condition being investigated.

3.14.A. Fetal Monitor - Fetal Nonstress Test

A Fetal Nonstress Test is covered as a diagnostic test when performed as part of routine monitoring of an ongoing pregnancy. MDHHS does not cover a room charge in addition to the test when it is being performed as part of routine monitoring of an ongoing pregnancy.

3.14.B. Pediatric Multi-Channel Recording

A pediatric multi-channel recording is a continuous and simultaneous recording of at least four channels and may include electrocardiogram (ECG), thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Additional channels may be appropriate and do not have to include an electroencephalogram (EEG).

MDHHS policy covers two multi-channel recordings per year per beneficiary under age 21 when provided by qualified personnel and interpreted by the physician. The physician must obtain PA if more than two tests per year are considered medically necessary and must provide a copy of the PA for the hospital's medical record.

Multi-channel recordings are not covered in the beneficiary's home.

3.15 Emergency Department Services

3.15.A. Screening Exam and Stabilization

MDHHS and its contracted health plans must follow the applicable requirements and definitions of the federal EMTALA 42USC§1395dd.

Medicaid policy covers the medical screening examination, any ancillary service(s) if performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the patient's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are billed to MDHHS. For Medicaid beneficiaries enrolled in a MHP, these services are billed to the beneficiary's MHP.

Facility charges for the ED screening exam are included in the hospital inpatient admission when services occur at the same facility. If the patient is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately. In both instances, the professional fees for medical screening and stabilization in the emergency room are reimbursed separately from the facility fees.

3.15.B. Treatment of Emergency Medical Condition

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the federal Balanced Budget Act of 1997 and its regulations.

An emergency may exist whether the patient is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the patient's medical record.

3.15.C. Treatment of Non-emergency Medical Condition

If the medical findings from the screening determine that the patient's condition does not meet the definition of an emergency medical condition, but requires additional follow-up treatment, the following rules apply:

- MHP enrollees must be referred to their primary care provider for treatment, or the ED can contact the MHP to request authorization to provide the treatment. The hospital must document all telephone calls made to the enrollee's MHP for the purpose of requesting post-stabilization authorization. If the MHP fails to respond within one hour to the request for additional services beyond those required for stabilization, the request for authorization is deemed approved.
- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurances frequently require that the primary care provider for the private insurance perform follow-up treatment. If the private insurance refuses payment for treatment because their rules were not followed, MDHHS does not pay for services. Medically necessary services not covered by the primary insurer that are covered by Medicaid are reimbursed if the Medicaid coverage requirements are followed.
- FFS Medicaid beneficiaries without private health insurance should be encouraged to obtain treatment from their primary care provider. However, treatment may be rendered in the ED and does not require PA.

3.15.D. Psychiatric Screening and Stabilization Services

Screening and stabilization of a psychiatric emergency does not require PA. A psychiatric emergency is defined as a situation in which an individual must be treated to protect them from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability or could reasonably be expected to intentionally or unintentionally injure themself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for them or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

If the treating hospital determines that the beneficiary requires post-stabilization psychiatric services, the hospital must contact the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for PA. The need for PA includes, but is not limited to, inpatient psychiatric care, partial hospitalization, and/or specialty mental health services. If a beneficiary requires inpatient psychiatric hospitalization and is admitted directly from the ED to the same facility, the local PIHP/CMHSP must prior authorize the admission.

If the beneficiary is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately.

In both instances, the professional fees for medical screening and stabilization in the ED are reimbursed separately.

3.16 Hearing Services

Hospitals may bill for speech and hearing evaluations, testing, and therapy for beneficiaries of all ages.

Audiology services other than newborn hearing screening tests must be provided by:

- A licensed audiologist.
- An audiologist candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license) supervised by a licensed audiologist.
- An audiology student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed audiologist.

Standards of practice must conform to those published in ASHA Preferred Practice Patterns for the Profession of Audiology. Audiologic test equipment and hearing aid test equipment used must conform to applicable American National Standards Institute (ANSI) criteria.

The following equipment must be available to audiologists providing services to infants less than six months of age:

- Infant Diagnostic Testing
  - Tone Burst ABR; and
  - Bone Conduction ABR; and
  - High Frequency Immittance; and
  - Otoacoustic Emissions
- Infant Hearing Aid Evaluation, Selection, and Follow-Up
  - Infant Predictive Method (e.g., Desired Sensation Level); and
  - Real-Ear to Coupler Difference

MDHHS requires that all Medicaid-covered newborns be screened using the auditory brainstem response (ABR) method and/or evoked otoacoustic emissions (EOAE) method as recommended by the American Academy of Pediatrics (AAP).

- Hospitals with 15 or more Medicaid deliveries per year must provide newborn hearing screening using the policies and procedures recommended by the AAP.
- Hospitals with less than 15 Medicaid deliveries per year may provide the service or advise the physician, physician assistant or advanced practice registered nurse to refer the newborn for the hearing screening prior to age one month.

For hospitals that provide EOAE and/or ABR newborn hearing screening, reimbursement is included in the calculation for the DRG. MDHHS recommends hospitals that provide delivery services have qualified staff to:

- Develop screening protocol.
- Appropriately train staff to perform screenings and, in matters of confidentiality, recognition of psychological stress for the parents or guardians, infection control practices, and established policies and procedures for handling newborns in the hospital.
- Develop a system for monitoring the performance of screenings.
- Inform parents/guardians about the procedure(s), potential risks of hearing loss, and the benefits of early detection and intervention.
- Allow parents/guardians an opportunity to decline screening. (Providers must document in the medical record if screening was declined.)
- Delineate responsibility for documenting screening results.
- Develop methods for communicating results in a sensitive and timely manner to the parents/guardians and the physician. If repeat screening is recommended following discharge, establish procedures for appropriate follow-up.
- Report critical data to the State's monitoring program.

3.17 Hyperbaric Oxygen Therapy

Medicaid covers hyperbaric oxygen therapy when provided in a hyperbaric chamber for selected indication (e.g., decompression illness, gas gangrene, etc.). MDHHS follows Medicare's billing guidelines. It is not to be used as a replacement for standard medical management.

3.18 Hysterectomy

Federal regulations prohibit Medicaid reimbursement for hysterectomies solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications which, alone, do not indicate a hysterectomy.

A hysterectomy is covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render them permanently incapable of reproducing. The beneficiary or their representative must sign a written acknowledgment of receipt of that information using the Acknowledgment of Receipt of Hysterectomy Information form (MSA-2218). All items on the MSA-2218

must be completed. The beneficiary (or representative) and the physician (MD or DO) must sign the form. (Refer to the Forms Appendix for a sample form.)

The Acknowledgment of Receipt of Hysterectomy Information form is not required if the beneficiary was already sterile before the hysterectomy.

Refer to the Practitioner Chapter of this manual for instructions regarding the completion and submission of the MSA-2218.

3.19 Injections/Intravenous Infusions

MDHHS covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment. In the outpatient hospital (OPH) or Ambulatory Surgical Center (ASC), reimbursement generally follows CMS Outpatient Prospective Payment System (OPPS) guidelines. Injectables paid differently than CMS OPPS are listed on the MDHHS OPPS Wraparound Code List for OPH or ASC. (Refer to the Directory Appendix for website information.)

A list of outpatient physician-administered drugs and biological products carved out from MHPs is maintained on the MDHHS website. Information regarding prior authorization (PA) requirements is also available on the MDHHS website. (Refer to the Directory Appendix for website information. Refer to the Billing & Reimbursement for Institutional Providers chapter for billing instructions.)

Refer to the Pharmacy Chapter of this manual for information regarding Medicare Part D.

3.20 Labor & Delivery/Nursery

MDHHS covers the labor and/or delivery room(s) or when an active labor does not progress to delivery. During active labor, MDHHS covers a fetal contraction or fetal nonstress test in addition to the labor and delivery room charge. When there is no active labor, MDHHS does not cover labor and/or delivery room charges for fetal monitoring or treatment of other medical conditions.

In an inpatient hospital, services are included in the DRG payment. Inpatient newborn nursery services are covered and must be billed under the newborn's ID number. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for additional information.)

3.20.A. Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation

To reduce the rate of elective, non-medically indicated delivery prior to 39 weeks completed gestation, it is the expectation of MDHHS that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery evidence-based guidelines (EBGs).

To ensure that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery EBGs, each hospital must have a completed Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation (MSA-1755) on file with MDHHS. A copy of the form is provided in the Forms

Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Providers are expected to report the appropriate NUBC condition codes for gestational age on the mother's hospital claim when the delivery is related to cesarean sections or inductions.

3.21 LABORATORY

Medicaid covers laboratory services performed by a clinical laboratory located in or as part of a hospital when it is certified to perform the specialties or subspecialties of tests billed. The laboratory must hold a CLIA certificate of registration, compliance (COC), or accreditation (COA) from the Centers for Medicare & Medicaid Services (CMS).

Medicaid covers hospital laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury and laboratory tests associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF).

Covered laboratory and pathology services must be:

- Recommended and ordered by the beneficiary's treating physician, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM according to their scope of practice.
- Provided in accordance with evidence based generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site, and duration for the beneficiary's symptoms, diagnosis, illness, or injury.
- Used in the clinical management of the beneficiary's specific medical condition.
- Provided in accordance with all applicable Medicaid clinical criteria, requirements, policies, and/or provisions of coverage.
- Performed in a laboratory appropriately certified by the Clinical Laboratory Improvement Amendments (CLIA).

The beneficiary's medical record must include sufficient documentation to support the medical necessity of the laboratory service regardless of where the tests are performed. The documentation must include a description of the beneficiary's symptomatology and other findings that have led the practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

Generally, MDHHS follows Medicare's current OPPS laboratory coverage policies as closely as possible and appropriate. In those instances where program differences require coverage disparity, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified services will appear on the MDHHS OPPS Wraparound Code List and reimbursement rates will appear on the Carrier Priced Laboratory Codes List. Both lists are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements.

3.21.A. Billing and Reimbursement

Laboratory services provided by outpatient hospitals are reimbursed through the Medicaid Outpatient Prospective Payment System (OPPS). Laboratory tests provided in conjunction with other hospital services are generally packaged as ancillary services and do not receive separate reimbursement unless otherwise indicated by the procedure code's OPPS payment status indicator and/or determined under OPPS claim processing rules. Laboratory services performed (either directly or under arrangement) for non-hospital patients (i.e., those who are neither a registered outpatient nor inpatient hospital patient) are considered performed by a hospital outreach laboratory and may be eligible for separate Medicaid reimbursement.

The laboratory's CLIA number must be present on the claim for laboratory services to be considered for reimbursement.

Outpatient laboratory services are billed using the appropriate HCPCS code and reimbursement includes the collection of the specimen(s), the analysis, and the lab test results. MDHHS performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner.

Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner.

Medicaid covers laboratory services provided in a provider-based outpatient hospital clinic when they are appropriate to be performed in a clinic setting. Beneficiaries are treated as hospital outpatients for billing purposes and laboratory services must be reported using the institutional claim format. Refer to the Hospital chapter for complete billing and reimbursement information.

Laboratory reimbursement to the inpatient hospital is through the DRG payment.

3.22 Mental Health and Substance Abuse Services

Most mental health services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services.

Medical/physical health care services (beyond the admission history and physical) and/or physician-ordered medical (nonpsychiatric) consultations required for Medicaid beneficiaries while they are receiving psychiatric inpatient or partial hospitalization services are not the responsibility of the PIHP/CMHSP. For FFS beneficiaries, these services are billed directly to MDHHS. For beneficiaries enrolled in a MHP, the services must be billed directly to the MHP. These services may require PA.

(Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for additional information.)

3.22.A. Acute Inpatient Medical Detoxification

Medically necessary inpatient detoxification services are covered only in a life-threatening situation. Medicaid does not cover inpatient detoxification if the beneficiary is simply incapacitated and not in a life-threatening situation. Acute medical detoxification services may be provided by a Medicaid-enrolled hospital without authorization from a PIHP. Acute detoxification services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries.

For additional substance abuse services, hospitals must refer beneficiaries seeking inpatient acute detox services to the regional PIHP.

3.22.B. Inpatient Psychiatric Services

Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Coverage for inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state-owned, is limited to eligible beneficiaries under age 21 and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, they would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following their 21st birthday, coverage terminates on the discharge date.

All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.22.C. Psychiatric Partial Hospitalization

Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.

All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.22.D. Substance Abuse Services

Medicaid covers acute care detoxification in the inpatient hospital as a FFS benefit. Reimbursement is made directly by MDHHS for both FFS beneficiaries and MHP enrollees.

Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria as reflected in the physician's orders and patient care plan:

- Vital signs, extreme and unstable.
- Uncontrolled hypertension, extreme and unstable.
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus.
- Insulin-treated diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an emergent/urgent condition.

3.22.E. Other Substance Abuse Services

Medicaid covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.22.F. Substance Use Disorder Services Through Prepaid Inpatient Health Plans

The regional PIHP may authorize the following specialized services:

- Outpatient Substance Abuse Treatment
- Assessment, Diagnosis, Beneficiary Placement and Referral
- Intensive Outpatient Counseling
- Approved Pharmacological Supports (Methadone)

Questions regarding substance abuse services should be directed to the regional PIHP.

3.23 Organ Transplants

Organ and tissue transplant services are covered when the transplant is likely to prolong life and restore a range of physical and social function to activities of daily living. All other medical and surgical therapies expected to affect short- and long-term survival must have been tried or considered.

Refer to the Hospital Reimbursement Appendix for information about MDHHS reimbursement for Transplant Services.

For other organ transplant services not described by a specific DRG, the hospital must provide a note/remark on the claim of the type of transplant (i.e., small bowel transplant) performed. All organ transplant claims suspend for manual review of documentation. A copy of the PA letter must be submitted with the claims. Providers must note "PA Letter submitted" in the Remarks section of the claim.

3.23.A. Coverage Criteria

For purposes of this coverage, the term 'organ' is defined as kidney, liver, heart, lung, pancreas, intestine (including the esophagus, stomach, small and/or large intestine, or any portion of the gastrointestinal tract), any vascularized composite allograft, or other organ defined in the National Organ Transplant Act of 1984, as amended, and hematopoietic stem/poietic stem/progenitor cells, cornea, bone and skin. The following criteria must be satisfied for the coverage of organ transplant services:

- Transplant services meet the requirements of Section 1138(B) of the Social Security Act, hospital protocols for organ procurement, Food and Drug Administration regulations, standards for organ procurement agencies, and transplant services as defined under State law where applicable.
- In making the selection of beneficiaries undergoing the transplant procedure, similarly-situated individuals are treated alike.
- Transplant services must be reasonable in their amount, duration, and scope to achieve their purpose.

Organ and tissue transplant services, including inpatient and outpatient, pre- and post-operative medical, surgical, hospital, physician, behavioral health, and related transportation services, are covered for eligible beneficiaries when medically necessary.

Covered services include:

- Pre-operative care, including required dental services to facilitate appropriate perioral health and hygiene
- Transplant care, including facility and professional fees
- Organ procurement fees, including donor fees
- Post-transplant care, including immunosuppressant drugs
- Psychological assessment
- Living donor expenses provided throughout the procurement process

3.23.B. General Requirements for Transplant Programs

Transplant services for organs defined in the National Organ Transplant Act of 1984, as amended, must be provided in a facility:

- That is a member of the Organ Procurement and Transplantation Network (OPTN) where applicable to the transplanted organ.
- For heart, lung, liver, and bone marrow transplants, has a current and approved Michigan Certificate of Need.

3.23.C. Organ Specific Criteria

The following organ-specific criteria lists program and prior authorization (PA) requirements. Other organ transplants may be covered with PA on an individual basis when the services performed are evidence-based and provided within generally accepted standards of medical practice. Combination of multiple organ transplantations will be considered on an individual basis and requires PA.

NOTE: Medicaid Health Plans and Integrated Care Organizations may develop PA requirements, utilization management, and review criteria that differ from Medicaid requirements. Beneficiaries who are enrolled in a Medicaid Health Plan or Integrated Care Organization must follow the plan's PA procedures to obtain approval for organ transplants.

Organ	Medical Necessity Criteria	Approval Duration	Required Documentation
Heart (May be done in combination with lung transplant)	End-stage heart disease not remediable by more conservative measures and amenable to surgical intervention, and diagnoses for which transplant provides best therapeutic potential.	▪ Initial authorization: 1 year ▪ Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated Practitioner Special Services Prior Approval – Request/Authorization (MSA-6544-B) form. If submitting electronically via direct data entry in the Community Health Automated Medicaid Processing System (CHAMPS), this PA request form is not required. • Medical documentation with ejection fraction and recommendation for transplant completed by a cardiologist, transplant surgeon/team • Psychosocial assessment

Organ	Medical Necessity Criteria	Approval Duration	Required Documentation
			• Approval letter from transplant team/committee
Lung (May be done in combination with heart transplant)	Pulmonary disease not remediable by more conservative measures and amenable to surgical intervention, for which transplant provides best therapeutic potential.	• Initial authorization: 1 year • Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated MSA-6544-B form. If submitting electronically via direct data entry in CHAMPS, this PA request form is not required. • Medical documentation, including recommendation for transplant completed by a pulmonologist, transplant surgeon/team • Psychosocial assessment • Approval letter from transplant team/committee
Kidney	End-stage renal disease not remediable by more conservative measures and amenable to surgical intervention, and diagnoses for which transplant provides best therapeutic potential.	Does not require prior authorization.	Documentation to be maintained in the beneficiary's medical record: • Assessment and recommendations of suitability for transplantation completed by a nephrologist, transplant surgeon/team • Psychosocial assessment
Liver	Liver disease not remediable by more conservative measures and amenable to surgical intervention, for which transplant provides best therapeutic potential. Split-liver living donor transplant will	• Initial authorization: 1 year • Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated MSA 6544-B form. If submitting electronically via direct data entry in CHAMPS, this PA request form is not required. • Medical documentation including Model for End-Stage Liver Disease (MELD) score (>12 years of age); Pediatric End-Stage Liver Disease (PELD) score (for <12

Organ	Medical Necessity Criteria	Approval Duration	Required Documentation
	be considered in appropriate circumstances.		years of age) and recommendation for transplant completed by a hepatologist, transplant surgeon/team • Psychosocial assessment • Approval letter from transplant team/committee
Pancreas	Pancreatic disease/failure not remediable by more conservative measures and amenable to surgical intervention for which transplant provides the best therapeutic potential.	• Initial authorization: 1 year • Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated MSA-6544-B form. If submitting electronically via direct data entry in CHAMPS, this PA request form is not required. • Medical documentation, including recommendation for transplant completed by an endocrinologist, gastroenterologist, transplant surgeon/team • Psychosocial assessment • Approval letter from transplant team/committee
Bone Marrow/Hematopoietic Stem Cell	Hematopoietic, bone marrow proliferative, or other diseases not remediable by more conservative measures and amenable to transplant intervention, and diagnoses for which transplant provides best therapeutic potential.	• Initial authorization: 1 year • Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated MSA-6544-B form. If submitting electronically via direct data entry in CHAMPS, this PA request form is not required. • Medical documentation, including recommendation for transplant completed by a hematologist, metabolic geneticist, oncologist, transplant surgeon/team • Psychosocial assessment

Organ	Medical Necessity Criteria	Approval Duration	Required Documentation
			• Approval letter from transplant team/committee
Cornea	Corneal disease or trauma not remediable by more conservative measures and amenable to surgical intervention, and diagnoses for which transplant provides best therapeutic potential.	Does not require prior authorization.	Documentation to be maintained in the beneficiary's medical record: • Assessment and recommendations of suitability for transplantation completed by an ophthalmologist, transplant surgeon/team • Psychosocial assessment
Intestine	Intestinal disease not remediable by more conservative measures and amenable to surgical intervention, and diagnoses for which transplant provides the best therapeutic potential.	• Initial authorization: 1 year • Continuation of authorization: Request extended prior authorization as needed, and submitted with: ➢ Updated medical documentation ➢ Updated psychological/social work assessment	• Completed, signed, and dated MSA-6544-B form. If submitting electronically via direct data entry in CHAMPS, this PA request form is not required. • Medical documentation, including recommendation for transplant completed by a gastroenterologist, intestinal transplant surgeon/team • Psychosocial assessment • Approval letter from transplant team/committee

3.23.D. Prior Authorization

Prior authorization (PA) is required for beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants. If transplantation of additional organ(s) is to occur during the same operative session as a cornea or kidney transplant, PA is required.

PA for transplant services, where applicable, is reviewed on a case-by-case basis. Approval is based on critical medical need for transplantation and a maximum likelihood of successful clinical outcomes with consideration for the following:

- All other medical and surgical therapies that might be expected to affect short- and long-term survival must have been tried or considered.
- The beneficiary is not in an irreversible terminal state and the transplant is likely to prolong life and/or restore a range of physical and social function to activities of daily living.

If the transplant occurs at a Medicaid-enrolled, in-state hospital, only the transplant services require PA. If the transplant is to be performed at an out-of-state hospital, both the psychosocial assessment and the transplant must be separately prior authorized.

In the event the organ transplantation is unable to be secured within the prior authorized timeframe, a request for continued authorization may be submitted and must include updated documentation. A Prior Authorization Certification Evaluation Review (PACER) for the hospital admission is still required per current policy. (Refer to the Hospital Chapter for more information.)

3.23.D.1. Psychosocial Assessment

For those transplants requiring PA, prior to the organ transplant, the beneficiary must have a psychosocial assessment at a qualified transplant center. The assessment is conducted to assist in determining a beneficiary's psychological and social readiness for the demands and stresses associated with transplant surgery, recovery, and rehabilitation. When the psychosocial assessment indicates the beneficiary may require additional supports to overcome perceived or identified challenges during the transplant process, MDHHS will require additional information to determine the beneficiary's ability to successfully achieve the necessary treatment and healthcare requirements pre-/post-transplant.

If the transplant center determines the beneficiary is a transplant candidate, the attending physician must submit the results from the psychosocial assessment and medical evaluation with the PA request to the MDHHS Program Review Division for evaluation by the Office of Medical Affairs (OMA). Requests for beneficiaries with Children's Special Health Care Services (CSHCS)-only coverage must also be submitted to the Program Review Division.

(Refer to the General Information for Providers chapter, Children's Special Health Care Services chapter, and the Directory Appendix for additional language and webpage location of Fee-for-Service Medicaid Prior Authorization Organ Transplant Criteria.)

3.23.D.2. Third Party Liability (or Coordination of Benefits)

PA is not required if Medicare makes payment and Medicaid liability is limited to coinsurance and deductible. If a Medicare application is pending, the provider must indicate that on the PA request and notify MDHHS when the determination is made. All other insurance resources must be exhausted before Medicaid is billed. The denial notice(s) must be submitted with the claim. (Refer to the Coordination of Benefits chapter for additional policy on other insurance.)

3.23.E. Donor and Donor Search

Medically necessary expenses incurred by a Medicaid-eligible or non-eligible living donor that are directly associated with a Medicaid-covered transplant may be covered. The donor must exhaust all possible insurance sources before Medicaid is billed for the services.

Covered services include:

- Evaluation to determine if the person is a candidate for living donation
- Donation surgery
- Post-operative care through the procurement process
- Transportation and lodging for related medical services
- Paired organ donation

Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to the organ transplant surgery. Should the Medicaid-covered beneficiary expire or loses Medicaid eligibility, donor services will continue to be covered.

When the donor search does not result in an organ acquisition and transplant, MDHHS reimburses for a donor search and related charges when billed as an outpatient service. Providers are required to submit a copy of the PA letter for the transplant with the claim and include a comment on the claim that the donor search was unsuccessful.

If the beneficiary is Medicaid-eligible and the donor is not Medicaid-eligible, providers must bill all services under the beneficiary's ID Number and provide complete documentation. If the donor and beneficiary are both Medicaid-enrolled, providers must bill the services under their respective Medicaid ID numbers.

3.23.F. Medicaid Organ Donor for Non-Medicaid Recipient

When a Medicaid beneficiary is an organ donor for a non-Medicaid enrolled recipient, the acquisition of the organ is the responsibility of the recipient's health insurance. (Refer to the Billing & Reimbursement chapters for additional billing information.)

3.23.G. Transportation and Lodging

MDHHS reimburses for transportation and lodging expenses associated with the evaluation and transplant for the qualified organ recipient and one accompanying individual (e.g., spouse, parent, guardian).

(Refer to the Non-Emergency Medical Transportation Chapter for further information.)

3.24 Outpatient Observation Services

Observation is a defined set of clinically appropriate specific services that include ongoing short-term treatment, assessment and reassessment before deciding whether a beneficiary requires further

treatment as a hospital inpatient or discharge from the outpatient hospital. Observation services must also be reasonable and necessary to be covered.

MDHHS follows Medicare's coverage and reimbursement policies related to observation services.

3.25 Personal Items

Personal comfort and convenience items (e.g., toiletries, slippers, hospitality kits, etc.) cannot be billed to MDHHS.

3.26 Preadmission Diagnostic Services

MDHHS follows Medicare policy for all preadmission diagnostic services and other preadmission services (outpatient services treated as inpatient) with a few exceptions in compliance with the law.

All non-diagnostic services rendered in the three-day window prior to the inpatient hospital admission may not be billed separately and must be bundled into the inpatient stay, unless the hospital can document they are unrelated services. MDHHS aligns with Medicare billing guidelines.

3.27 Radiology

MDHHS covers Medicaid enrolled hospitals for the following medically-necessary radiology services, including diagnostic imaging and radiation therapy and other imaging services:

- Necessitated by injury or disease, including benign or malignant conditions;
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, or advanced practice registered nurses.

The medical record must contain documentation of medical necessity to support all radiology services billed.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services follows Medicare Outpatient Hospital Prospective Payment System (OPPS) rules and includes the use of the facility, equipment, supplies, and attendant personnel required to provide the service. Prior authorization may be required. Refer to the CHAMPS Code Rate and Reference tool for guidance.

MDHHS reimburses for diagnostic imaging and radiation therapy services, including:

Computerized Axial Tomography (CT) Scanning	CT scanning is not covered for routine screening, nonspecific diagnoses, or in situations where less costly diagnostic methods are appropriate. CT scanning procedures must be provided on equipment that has an approved Certificate of Need (CON) on file with MDHHS.
Radiation Therapy	Treatment must be provided on equipment and in locations that meet Federal and State regulatory requirements.

Ultrasonography	Ultrasound procedures are reimbursed when there is clinical evidence in the beneficiary's record to substantiate the medical need for such services. Ultrasound procedures are generally not covered when used as screening procedures or on a routine basis. When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures. Claims for diagnostic ultrasound procedures that are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure. Claims are rejected if the documentation does not support the need for the repeat diagnostic procedure.

3.28 Rehabilitation Services

MDHHS follows Medicare's coverage and reimbursement policies related to Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR).

MDHHS reimburses covered services for CR and ICR services for beneficiaries with chronic and specific medical (diagnosis code specific) conditions, respectively. Hospitals and physicians, any combination of services, may provide the rehabilitation sessions. ICR programs must be approved and certified.

MDHHS reimburses covered services for PR for beneficiaries with obstructive pulmonary disease and other specific medical diagnosis.

3.29 Sterilization

MDHHS covers sterilization procedures when specific requirements are met. A sterilization procedure is defined as any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687). (Refer to the Forms Appendix for a sample form and to the Directory Appendix for website information.)

Sterilizations are reimbursed only if:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In some cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g., diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.

Federal regulations require that the completed MSA-1959/HHS-687 must be submitted to MDHHS before reimbursement can be made for any sterilization procedure. A copy must be attached to the claim form unless submitted via fax prior to filing the claim. MDHHS allows for submission of MSA-1959/HHS-687 forms via fax to encourage electronic billing and reduce administrative burden. This process can also pre-confirm the acceptability of the completed consent form and reduce costly claim rejections. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information regarding the completion and submission of the MSA-1959/HHS-687.

3.30 SURGERY

MDHHS reimburses for surgeries performed in an inpatient hospital through the DRG payment.

When an ambulatory surgery is performed in the inpatient hospital setting, the physician/dentist must provide exception rationale justifying the need for an inpatient setting. Acceptable rationale includes:

- A medical condition that requires prolonged postoperative observation by skilled medical personnel (e.g., heart disease, severe diabetes);
- A pre-existing condition that significantly increases the risk of using anesthesia;
- The beneficiary has been admitted to a hospital for another procedure or condition, and the surgeon determines that additional surgical procedures are necessary;
- An unrelated procedure is being done simultaneously which, by itself, requires hospitalization;
- Another surgical procedure is expected to follow the initial procedure (e.g., gynecological laparoscopy followed by an oophorectomy);
- Technical difficulties, as documented by admission or operative notes; or
- Adequate outpatient facilities are not available within a reasonable distance (i.e., 40 miles) requiring the surgery to be rendered on an inpatient basis. In this case, MDHHS allows a one-day inpatient hospital stay, unless a longer stay is medically necessary.

If the physician planned to perform the surgery on an outpatient basis, but more extensive surgery was needed or complications developed and the beneficiary had to be admitted, a Prior Authorization Certification Evaluation Review (PACER) number is not needed for the admission. This type of admission is considered urgent or emergent. The need for the admission is, however, subject to post payment review by MDHHS.

MDHHS follows Medicare's Inpatient Only policy for outpatient surgeries.

MDHHS covers a second surgical opinion if the beneficiary or the physician/dentist requests one.

3.30.A. Operating Room

Inpatient coverage and reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT support code(s) operating room services and surgical supplies. The main payment methodology for the OPPS is the APC which is used by Medicare. Per Federal Regulations, the MDHHS OPPS uses Medicaid NCCI and Medically Unlikely Edit (MUE) values for OPH claims processing. Medicaid NCCI and MUE values are reviewed with the quarterly file updates.

3.30.B. Recovery Room

MDHHS policy covers routine supplies, anesthesia, and recovery room use. Most drugs are considered to be an integral part of a surgical procedure. Payment for these items is packaged into the APC payment for the surgical procedure.

Inpatient coverage and reimbursement is through the DRG payment.

Outpatient providers must bill appropriately for the Recovery Room. MDHHS follows Medicare's coverage and reimbursement policies for outpatient providers.

3.30.C. Cosmetic Surgery

Hospital charges related to cosmetic surgery are not reimbursable without PA for the surgery. The physician/dentist must furnish the hospital with a copy of the PA letter for the surgery, as well as the PACER number for the admission.

3.31 Occupational Therapy

Occupational Therapy services provided during an inpatient stay do not require PA for reimbursement. Refer to the Standards of Coverage and Service Limitations Section of the Therapy Services Chapter for criteria.

Refer to the Standards of Coverage and Service Limitations Section of the Therapy Services Chapter for therapy provided in the outpatient hospital setting. The MDHHS OPPS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.32 Physical Therapy

Inpatient hospital physical therapy does not require PA for reimbursement. Refer to the Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.

The MDHHS OPPS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.33 Therapy, Speech-Language Pathology

Speech-language pathology services provided during an inpatient admission do not require PA.

Refer to the Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting. The MDHHS OPPS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.34 Telemedicine

A hospital can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.35 Weight Reduction

MDHHS policy covers obesity treatment when done for the purpose of controlling life-endangering complications such as hypertension and diabetes. This does not include treatment specifically for obesity, weight reduction and maintenance alone. The physician must request PA and document that other weight reduction efforts and/or additional treatment of conservative measures to control weight and manage the complications have failed.

The request for PA must include:

- The medical history;
- Past and current treatment and results;
- Complications encountered;
- All weight control methods that have been tried and failed; and
- Expected benefits or prognosis for the method being requested.

If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter their lifestyle following surgical intervention must be included.

Mail requests to Office of Medical Affairs (OMA). (Refer to the Directory Appendix for contact information.)

If the request is approved, the provider receives an authorization letter for the service, including billing instructions. A copy of the authorization letter must be attached to all claims submitted to MDHHS for weight reduction services.

SECTION 4 – UTILIZATION REVIEW

4.1 NONCOVERED ADMISSIONS

For Medicaid reimbursement, all inpatient admissions must be medically necessary and appropriate. MDHHS does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), diagnostic x-rays
- Observation
- Occupational therapy (OT)
- Patient education
- Physical therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction; weight control (unless prior authorized)

Inpatient claims with discharge date prior to October 1, 2014 where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDHHS as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit. Any accommodations or ancillary services provided during nonallowable admissions or parts of stays will not be reimbursed.

Medically inappropriate or unnecessary admissions claims with dates of discharge on or after October 1, 2014 may be resubmitted as outpatient claims (Type of Bill 013x) for all outpatient services and any inpatient ancillary services performed during the inpatient stay.

Hospitals may not bill beneficiaries for any medical charges for goods and services provided during a nonallowable admission. The beneficiary is assumed to be following the physician's advice.

4.2 INPATIENT AND OUTPATIENT POST-PAYMENT REVIEWS

MDHHS and/or its audit contractor will perform automated reviews and medical record reviews on inpatient and outpatient services that have been paid. An automated review is a re-examination of a claim payment at the system level. These reviews will focus on errors in pricing, coverage, coding determinations and payment of duplicate claims. A medical record review is a more comprehensive comparison of a hospital's Medicaid claims against the hospital's medical records.

The objective of the MDHHS post-payment review process is to ensure that MDHHS reimbursement is for medically necessary care provided in the appropriate setting, that diagnostic and procedural information is valid, and that the care rendered meets current clinical and quality standards of practice. Cases are

reviewed using Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, clinical judgment and generic quality screens.

All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The audit will also ensure that the quality and intensity of hospital services conform to current and acceptable standards of medical practice and Medicaid policies, procedures, and coding guidelines.

4.3 CONFIDENTIALITY

As an agent of the State, the MDHHS audit contractor may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a hospital to make all records available to the contractor will result in denial of that case and subjects that hospital to Medicaid participation sanctions.

SECTION 5 – DISCHARGE PLANNING

As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. The medical and social services personnel of the hospital should assist in this effort. If so requested by the hospital, the local MDHHS office assists in relocating the beneficiary. The following subsections explain possible alternatives for care.

5.1 HOME HELP

The beneficiary is able to remain in their own home. Home Help providers assist the beneficiary with activities of daily living (ADL), instrumental activities of daily living (IADL), and complex care tasks. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination (excluding the combination of Home Help and MI Choice Waiver services) as defined in Medicaid policy.

5.2 HOME HEALTH

The beneficiary resides in their own home or other place of residence (e.g., foster care, home for the aged), is under a physician's (MD, DO) care, and requires intermittent nursing care for a specified period of time. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination as defined in Medicaid policy.

5.3 HOME FOR THE AGED

The beneficiary (age 62 or older) receives supervision and non-nursing care in a licensed home. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

5.4 ADULT FOSTER CARE HOME

The beneficiary is in a licensed home that provides supervision, assistance, protection, and personal care, in addition to room and board. This type of home does not provide continuous medical care. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

5.5 HOME AND COMMUNITY BASED WAIVER FOR THE ELDERLY AND DISABLED (MI CHOICE WAIVER PROGRAM)

The beneficiary must meet the eligibility criteria in the Michigan Medicaid Nursing Facility Level of Care Determination and require two waiver services, one of which must be Supports Coordination. Referrals are made to regional waiver providers who are responsible for screening and assessing the beneficiary for waiver eligibility. Once determined eligible, services are provided in the beneficiary's home to help the beneficiary remain as independent as possible. These services may include skilled nursing, respite care, counseling, etc.

Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

Michigan Medicaid Nursing Facility Level of Care Determination

The Michigan Medicaid Nursing Facility Level of Care Determination form must be completed for every Medicaid beneficiary prior to admission to the MI Choice Waiver. The MI Choice Waiver program agent must verify beneficiary appropriateness for services by completing the electronic web-based version of the form. Beneficiaries who do not demonstrate functional/medical eligibility through the electronic web-based tool are not eligible for the MI Choice Waiver Program.

Information regarding the Michigan Medicaid Nursing Facility Level of Care Determination process, the form, and the Field Definition Guidelines are on the MDHHS website. (Refer to the Directory Appendix for website information.)

While the MI Choice Waiver agent is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for the MI Choice Waiver using a copy of the form. A hospital may also use the Telephone Intake Guidelines to conduct an initial assessment of potential eligibility for the program. The Guidelines are also available on the MDHHS website.

5.6 Program of All-Inclusive Care for the Elderly (PACE)

The Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to the PACE. The PACE agent must verify beneficiary appropriateness for services by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for PACE.

Information regarding the LOCD process, the LOCD assessment, and the LOCD Field Definition Guidelines is on the MDHHS website. (Refer to the Directory Appendix for website information.)

While the PACE agency is the actual entity that must complete and conduct the online LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for PACE using a copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDHHS website.

5.7 Private Duty Nursing

The beneficiary requires more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. Private duty nursing (PDN) enables the beneficiary to remain in their home. This service is a benefit for beneficiaries under age 21.

If the beneficiary is enrolled in or receiving case management services from one of the following programs, the applicable program authorizes the PDN:

- Habilitation Supports Waiver (the Community Mental Health Services Program) and over age 21
- Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)

For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN services for persons with Medicaid coverage. A copy of the form is provided in the Forms Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.) This form is not to be used for beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.

For beneficiaries age 21 and older, this service is a waiver service that may be covered for qualifying individuals enrolled in the MI Choice Waiver or the Habilitation Supports Waiver.

5.8 Nursing Facility

If the beneficiary requires less than acute, continuous medical care, a nursing facility (NF) may be appropriate. This includes a nursing home, medical care facility, or hospital long-term care unit. The Beneficiary Eligibility Chapter of this manual contains information about the facility admission and discharge process. (Any other alternatives for care (e.g., Home Help) may not be provided to the beneficiary while they are in the nursing facility.)

Medicaid's reimbursement (per diem rate) to a nursing facility includes non-emergency transport of beneficiaries being admitted to a nursing facility from the hospital setting.

There are necessary components for determining eligibility for Medicaid nursing facility reimbursement.

- A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician. A stamped signature is not acceptable.
- With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.
- Verification of Medicaid financial eligibility for nursing facility care as determined by MDHHS.
- A Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission to a nursing facility. The purpose of the screening is to prevent placement of beneficiaries with mental illness, intellectual/developmental disability or a related condition into a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. Level I screening is documented on the Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification) form (DCH-3877). The Level I screening is part of the hospital discharge planning process and must be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

  The PASARR process is not required when:

  - An individual is admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

- An individual is admitted to, and residing in, a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- A resident is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.

All individuals identified by Level I screening as possibly having a mental illness, intellectual/developmental disability or a related condition (a "yes" response to any question on the DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined on the Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification form (DCH-3878) or MDHHS/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions.

(Refer to the Forms Appendix for a copy of the forms.)

- A Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to a nursing facility. The nursing facility must verify beneficiary appropriateness for nursing facility care by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for nursing facility care. Refer to the Coverages portion of the Nursing Facility Chapter for additional information regarding the LOCD.

  While the nursing facility is the actual entity that must complete and submit the LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for nursing facility care using a hard copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDHHS website.

5.9 Special Nursing Facility Placement

5.9.A. Medicaid Ventilator-Dependent Care

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services.

A request for placement must show that:

- The beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- The beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 207.

Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BIPAP.

If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post-acute setting. If there is no weaning potential and the beneficiary does not require rehabilitative services, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

The MHP is responsible for initiating disenrollment of a beneficiary by submitting the Request for Disenrollment Long Term Care form (MSA-2007) to MDHHS.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. The hospital cannot charge a beneficiary the difference between the hospital's charge and the MDHHS payment for nursing days.

When the beneficiary is in the hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the hospital discharge planner must provide the following documentation to the VDCU:

- History and physical from the current hospital admission;
- All consults from the current hospital admission;
- Any labs, diagnostic testing or procedures pertaining to or impacting the beneficiary's respiratory status; and
- Two to three days of current ventilator flow sheets.

For status of the authorization, the hospital discharge planner should contact the VDCU. The VDCU will initiate the actual prior authorization with Medicaid.

5.9.B. Complex Care

The Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. Prior authorization covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDHHS to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment

Program requirements:

- Referrals must come from the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.

If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate nursing facility contact as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.

5.10 Diapers for Home Use

The hospital should contact the Volume Purchase Contract vendor to determine if the beneficiary is currently receiving diapers through the Volume Purchase Contract. (Refer to the Directory Appendix for contact information.) If so, then no further action is required.

For beneficiaries who are not currently receiving diapers, the hospital must obtain a complete physician prescription. The hospital must fax the complete prescription to the contract vendor no later than 72 hours prior to discharge. A complete prescription must include:

- Medical diagnosis of condition causing incontinence (primary and secondary diagnosis)
- Specific type of diaper to be dispensed
- Duration of need
- Quantity of diapers needed for the first 30 days after discharge
- Required beneficiary information:
  - Full name
  - Medicaid and Medicare identification numbers
  - Full home address, including city, state and zip code
  - Home phone number
  - Name and phone number of contact person other than beneficiary to ensure delivery if beneficiary is not present

Diapers are covered for individuals age three and older if the following criteria are both met:

- Beneficiary has a medical condition resulting in incontinence and has failed to respond to a bowel/bladder training program; and
- The medical condition being treated results in incontinence, and the beneficiary would not benefit from a bowel/bladder training program.

HOSPITAL REIMBURSEMENT APPENDIX

SECTION 1 – OUTPATIENT [CHANGES MADE 4/1/2025]

Reimbursement to outpatient hospitals, including off-campus satellite clinics, rural emergency hospitals, hospital-owned ambulance services, freestanding dialysis centers (ESRDs), comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies for outpatient services is made in accordance with Medicaid's Outpatient Prospective Payment System (OPPS). Covered dental services provided in outpatient hospitals are reimbursed according to the Medicaid fee schedule. No facilities (i.e. critical access or children's hospitals) are excluded from Medicaid's Ambulatory Payment Classification reimbursement methodology. Payment made under OPPS is calculated utilizing current Medicare rates, with a MDHHS reduction factor applied, unless otherwise noted in this section. Separate OPPS reduction factors are established for Critical Access Hospitals (CAHs) and non-CAHs.

Dialysis services provided to an Emergency Services Only (ESO) beneficiary must include a diagnosis code for End Stage Renal Disease on Dialysis.

Reimbursement for outpatient hospital services will be monitored and adjustments will be made to the MDHHS reduction factor, as necessary, to ensure spending limits fall within the MDHHS appropriation. A wage index of 1.0 is applied for all hospitals. Medicare's APC weights are utilized. Services reimbursed at a percent of charges are paid a percentage of the individual hospital's charges for the service (i.e., pass-through payments). Updates of hospitals' Medicaid cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios. The default Medicaid cost-to-charge ratio is the average statewide Medicaid outpatient cost-to-charge ratio for out-of-state ratios. To maintain budget neutrality, CAHs that convert to rural emergency hospitals will retain the enhanced OPPS reduction factor for reimbursement. **(revisions made 4/1/2025)**

1.1 AMBULATORY PAYMENT CLASSIFICATION REIMBURSEMENT METHODOLOGY

The main payment methodology for the OPPS is the APC which is used by Medicare.

1.2 OUTPATIENT CODE EDITOR WITH AMBULATORY PAYMENT CLASSIFICATION

MDHHS uses Medicare's Outpatient Code Editor (OCE), including Medicaid National Correct Coding Initiative (NCCI), editing. Per Federal Regulations, the MDHHS OPPS uses Medicaid NCCI and MUE values for OPH claims processing. Medicaid NCCI and MUE values are reviewed with the quarterly file updates. The OCE is updated quarterly. The two main functions of the OCE are to identify errors and to assign APCs. In addition, the software performs the following functions when processing a claim:

- Edits a claim for accuracy of the submitted date;
- Assigns payment indicators;
- Determines if packaging is applicable;
- Determines the disposition of a claim based on generated edits;
- Computes discounts and outliers, if applicable;
- Determines payment adjustment, if applicable.

MDHHS uses proprietary edits that are not duplicated by the OCE to review beneficiary and provider eligibility, third party liability, quantity/frequency of services, diagnosis, and other information normally reviewed by the fiscal intermediary under the Medicare OPPS.

1.3 Status Indicators

MDHHS follows Medicare's single character status indicator assigned to each individual CPT or HCPCS code to identify if a code will be paid and how it will be paid.

For categories of codes that MDHHS covers differently than Medicare under its OPPS (wraparound codes), the following alpha-numeric status indicators are used.

MDHHS Specific Status Indicators

Status Indicator	Description	Comments
A1	MDHHS covered	
A2	Series-billed dialysis service (revenue codes 82x, 83x, 84x, 85x)	Paid based on associated MDHHS fee schedule
A3	Hospital-owned ambulance services	Paid based on associated MDHHS fee schedule
A4	Non-Medicare covered services (e.g., family planning, dental, sterilization, abortion, etc.)	Paid based on associated MDHHS fee schedule
A5	Non-Medicare covered adult vaccines	Paid based on associated MDHHS fee schedule
A6	Vaccines For Children	Zero payment; Vaccines For Children (VFC) program
A7	State Plan Reimbursement	
A8	Healthy Michigan Plan Only	
R1	MDHHS non-allowed item or service (e.g., aquatic therapy, infertility services, etc.)	Items, codes, and services that are not covered by MDHHS

1.4 Packaged/Bundled Services

MDHHS follows Medicare guidelines for packaged/bundled service costs. Services having a status indicator of "N" are considered packaged or bundled into other services. The costs of these services are allocated to the APC but are not paid separately.

Reimbursement to hospitals for outpatient services is made in accordance with Medicaid's maximum fee screens, the hospital's usual and customary (U&C) charges, or Medicare's reasonable costs, whichever is less.

1.5 Payment Calculation

Payments made under the MDHHS OPPS methodology are calculated utilizing the current Medicare conversion factors/rates with an MDHHS reduction factor (RF) applied to the calculated payment (Medicare fee x RF = Medicaid fee).

The MDHHS payment is the lesser of:

- the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or
- (for fee schedule items) the provider's charge, reduced by any contractual adjustments, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or
- the beneficiary's liability for coinsurance, copayments, and/or deductibles.

For claims when a provider bills charges less than the OPPS/APC amount for non-fee schedule items, the MDHHS payment liability is the APC amount minus any Medicare or other insurance payments up to the coinsurance, copayment, and/or deductible amount reported.

Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.6 Discounted Procedures

MDHHS follows Medicare rules for discounting payment for multiple, bilateral or discontinued procedures (OPPS status indicator "T").

1.7 Outlier Payments [Change Made 4/1/2025]

MDHHS follows Medicare's APC outlier payment policy. The MDHHS reduction factor is not applied to outlier payments. Submitted charges are used for all lines on a claim, including the packaged lines, for outlier calculations. **(text added 4/1/2025)**

1.8 Services Paid a Percent of Charges [Changes Made 4/1/2025]

Services that are paid a percent of charges are paid at a percentage of the hospital's charges for that service (e.g., pass-through payments). Each hospital's current Medicaid outpatient cost-to-charge ratio is used for the initial OPPS implementation. Updates of the Medicaid outpatient cost-to-charge ratios are done in step with inpatient operating ratio updates. For out-of-state hospitals, the default Medicaid cost-to-charge ratio is the average statewide Medicaid outpatient cost-to-charge ratio. The MDHHS reduction factor is not applied to services paid a percent of charge. **(text added 4/1/2025)**

1.9 Pass-Through Payments

Pass-through payments are generally for new drugs, biologicals, radiopharmaceutical agents, and medical devices. Drugs and devices having a status indicator of "G" or "H" receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. The MDHHS reduction factor is not applied to drugs or devices with a status indicator of "H".

1.10 Fee Schedules

MDHHS utilizes Medicare fee schedules with the MDHHS reduction factor applied, except as described above.

SECTION 2 - INPATIENT

2.1 SERVICES INCLUDED IN THE INPATIENT PAYMENT

The following services are included in the inpatient payment:

- All routine services (e.g., room and board, nursing).
- All diagnostic/ancillary services (e.g., radiology, pharmacy, therapists, supplies, pathology).
- While a patient is in the inpatient setting, the facility charges for any services performed by persons or entities other than the patient's hospital (e.g., an independent lab, a second hospital where no transfer occurs) are covered in the payment to the patient's hospital and must not be billed separately. All charges must be included on the inpatient claim of the patient's hospital. Any payments due to the second party are the responsibility of the patient's hospital.
- All pathology services that are performed by the pathologist but do not directly relate to the specific patient's care.
- All emergency room services provided by the hospital that result in an inpatient admission to that hospital. All charges must be included on the inpatient claim.
- An orthosis or prosthesis that is required for inpatient treatment, a surgical postoperative procedure or as a routine service of the hospital should be included as a supply on the inpatient claim and is reimbursed under the appropriate DRG.

Examples of items that are included in the inpatient payment are:

- Pacemakers
- Hip replacements
- Made-to-measure braces for compression fractures
- Compression stockings (TED, Jobst)
- Halos
- Immediate post-surgical or early fitting of prosthetic devices, etc.

2.2 SERVICES EXCLUDED FROM THE INPATIENT PAYMENT

The following services are excluded in the inpatient payment:

- An orthosis or prosthesis that is required for rehabilitation and will be utilized after discharge, and/or is required to address a long term, lifetime, permanent need. An orthotist/prosthetist must bill these items separately to Medicaid. Prior authorization (PA) must first be obtained for appropriate procedure codes.
- Except as noted above, outpatient services may not be separately billed while a beneficiary is in the inpatient setting. All charges must be included on the inpatient claim.

- Any services that are covered by Medicaid and excluded from the inpatient payment may be separately billed if the provider of the service is properly enrolled in the program and a claim is submitted appropriately.

The following are examples of services excluded from the inpatient payment. This list may not be all-inclusive:

- Anatomic pathology services provided directly by a pathologist.
- Orthoses/prostheses required for rehabilitation that will be utilized after discharge, and/or are required to address a long term, lifetime, permanent need. Additional examples of items that are excluded from the inpatient payment are a knee-ankle-foot orthosis or an ankle-foot orthosis.
- Professional services (e.g., practitioner, dental, podiatric, optometric).
- Services provided by a certified nurse midwife (CNM).
- Services provided by a certified registered nurse anesthetist (CRNA).
- Ambulance services.

2.3 3M™ All Patient Refined Diagnosis Related Groups System

Effective for inpatient discharges on or after October 1, 2015, the Medicaid diagnosis related grouper (DRG) reimbursement system uses the 3M™ All Patient Refined Diagnosis Related Groups (3M™ APR-DRG) system. The following sections apply to the 3M™ APR-DRG reimbursement system.

2.3.A. Reimbursement for Medical and Surgical Hospitals

2.3.A.1. Description of Medical/Surgical Episode File

The episode file is comprised of the underlying data used to calculate the statewide rate, relative weights, and alternate weights. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children's Special Health Care Services fee for service (FFS) paid claims and managed care encounters.

Each claim or encounter from the episode file is assigned a DRG value using the APR-DRG Grouper in effect nationally on October 1 of the applicable rate year. The data are adjusted to:

- Eliminate episodes for dual Medicare/Medicaid eligible beneficiaries, unless paid a full Medicaid DRG.
- Eliminate certain transplants and low day outlier episodes assigned to DRGs reimbursed by multiplying a hospital's operating cost-to-charge ratio by charges.
- Eliminate episodes without any charges or days.
- Assign alternate weights for neonatal services. Two sets of weights are calculated for the DRG classifications representing neonatal services (DRGs 580x-640x). These alternate weights are calculated based on episodes that are assigned to one of these DRGs and include charges for services in a Neonatal Intensive Care Unit (NICU). The

remaining claims assigned to these DRGs are used for the base weights. No other alternate weights are assigned.

- Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data is available).
- Limit episodes to those with a valid discharge status.
- Eliminate episodes with a zero dollar Medicaid liability.
- Eliminate episodes that qualify for the Short Hospital Stay rate.
- Determine the low day trim point and average length of stay. (Refer to the Relative Weights section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)
- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG. (Since DRGs 580x and 581x are transfer DRGs, all transfer costs are included within those DRGs.)
- Inflate the first year of episodes to the second year through application of an inflation factor derived from IHS Global Insight.
- Recognize area cost differences by dividing the charges for each hospital by an area wage index. (Refer to the Area Wage Index section of the Reimbursement for Medical/ Surgical Hospitals section of the State Plan for additional information regarding the area wage index.)
- Adjust charges for high cost outliers to remove the amount paid as an outlier. (Refer to the High Cost Outlier section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information regarding cost outliers.)
- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost-to-charge ratio. (Refer to the Cost-to-Charge Ratio section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information regarding cost-to-charge ratios.)

2.3.A.2. Statewide DRG Rates

Two statewide medical/surgical hospital DRG rates are developed by the state using the Episode File. For hospital DRG rate setting purposes, the medical/surgical Episode File is limited to those hospitals enrolled with the state as of October 1 of the applicable rate year. Two separate statewide rates are developed: one rate is developed for prospective payment system (PPS) hospitals and another rate is developed for hospitals designated as critical access by CMS as of October 1 of the applicable rate year. In the event a hospital status changes from PPS to critical access hospital (CAH), the state recognizes the hospital under CAH status as of the CMS effective date. The reverse is also true. If a hospital status changes from CAH to PPS, the state recognizes the hospital under PPS status as of the CMS effective date. Statewide rates are updated annually on October 1.

A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate

hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount paid prior to the change. Budget neutrality for CAHs is determined as a group, independent of PPS.

Hospitals' final DRG rates are calculated as follows:

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The case mix index adjusted cost for each hospital is summed.
- A hospital-specific standardized cost per discharge is computed.
  - Divide total adjusted costs by the total number of episodes.
  - Divide average costs by the case mix.
  - Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- The statewide rate per discharge is the weighted mean of all hospital-specific standardized costs.
- A rate adjustment is applied to designated level I and II trauma facilities.
- The statewide rate is adjusted by an Area Wage Index and Budget Neutrality Factor to determine the hospital's final DRG rate.

In developing the statewide DRG rate, the following data and calculations are used for each hospital:

1) Hospital's adjusted charges;
2) Inpatient cost-to-charge ratio;
3) Hospital's adjusted costs (line 1 x line 2);
4) Hospital's episodes;
5) Cost per discharge (line 3/line 4);
6) Hospital's case mix;
7) Standardized cost per discharge (line 5/line 6);
8) Establish statewide rate as weighted standardized cost per discharge ((∑line 7 x line 4)/∑ line 4);
9) Hospital's Area Wage Index;
10) Apply rate adjustment to designated level I and II trauma facilities;
11) Apply budget neutrality factor; and

12) Hospital's final DRG rate (line 8 x line 9 x line 10). The DRG rate is rounded to the nearest whole dollar amount.

The statewide rates are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.A.3. 3M™ APR-DRG Relative Weights

Michigan-specific relative weights are developed utilizing the adjusted costs from the Episode File. The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG. The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and low day outlier threshold for each DRG is available on the MDHHS website. (Refer to the Directory Appendix for website information.) Relative weights are updated annually on October 1.

The state establishes alternate weights for neonatal services from episodes that are assigned to one of the DRGs in the following range: 580x-640x. Effective, July 1, 2020, the NICU alternate weight reimbursement will apply to episodes with a DRG within 580x-640x and a minimum of one day with revenue code 0173 or 0174. Revenue codes reported should reflect the level of care provided to the patient in accordance with NUBC billing guidance. These weights are utilized for services rendered in a NICU. The remaining claims assigned to these DRGs are used for the base weights (non-alternate weights). No other alternate weights are assigned.

To ensure each relative weight adequately reflects resource utilization for a particular DRG in the state, the state requires that each DRG have a minimum of 10 episodes. If a DRG does not have at least 10 episodes, an alternative solution is applied as follows:

<u>State-Specific Relative Weight Methodology:</u>

- If the episode count for a DRG is 10 or more, use the relative weight setting methodology outlined. Otherwise:
  - For severity levels 1 through 3 where the targeted severity level is equal to *n*:
    - If the episode count for the next greater severity level is 10 or more, the following calculation is completed: (MI DRG Severity$_{n+1}$ Relative Weight) x (National DRG Severity$_n$ Relative Weight) / (National DRG Severity$_{n+1}$ Relative Weight) = (MI Relative Weight Factor$_n$)
    - Otherwise, (National DRG Severity$_n$ Relative Weight) x (MI Case Mix Factor$_n$)
  - For severity level 4:
    - If the episode count for the prior severity level is 10 or more, the following calculation is completed: (MI DRG Severity$_{n-1}$ Relative Weight) x (National DRG Severity$_n$ Relative Weight) / (National DRG Severity$_{n-1}$ Relative Weight) = (MI Relative Weight Factor$_n$)
    - Otherwise, (National DRG Severity$_n$ Relative Weight) x (MI Case Mix Factor$_n$)

- Where:
  - (MI Case Mix Factor$_n$) = sum of Michigan specific relative weights multiplied by the number of episodes if the number of episodes is 10 or more divided by the sum of National relative weights multiplied by the number of episodes if the number of episodes is 10 or more.
  - (MI Alternate Weight Case Mix Factor) = Average of (MI Alternate Weight DRG Severity) / (MI DRG Severity Relative Weight) for DRGs with an episode count of 10 or more.

- Further adjustments are necessary if the resulting adjustment described above is inconsistent with Michigan or National trends and data.
  - Example 1: If an episode count is between 10 and 20 and the alternate weight would be less than the standard relative weight, but other severity levels are not consistent with this, then apply the next severity level imputing method.
  - Example 2: If the episode count is between 10 and 20, the state may consider using the Alternate Weight Case Mix Factor applied to the National Alternate Weight if the alternate weight is not consistent with other severity levels of the same DRG.
  - All relative weights are subject to reasonableness testing.

Relative Weight Trim Points:

The following trim points are established for the relative weighting system. All relative weight trim points are subject to reasonableness testing.

- The low day trim point is used to determine whether an episode qualifies for a low day outlier and is established as follows.
  - If the episode count for a DRG is 10 or more, the low day trim point is set to the 3rd percentile of the length of stay for the DRG.
  - If the episode count for a DRG is less than 10, the low day trim point is set to the lesser of the national low day trim point or 3rd percentile of length of stay for the DRG.
  - If the episode count for a DRG is zero, the low day threshold is set to the national low day trim point for the DRG.
- The average length of stay (ALOS) is used to price claims episodes involving a transfer from a hospital and is established as follows.
  - If the episode count for a DRG is 10 or more, set the ALOS to the simple average length of stay for the DRG.
  - If the episode count for a DRG is less than 10, set the ALOS to the lesser of national ALOS or the simple average length of stay for the DRG.
  - If the episode count for a DRG is zero, set the ALOS to the national ALOS.

2.3.A.4. Area Wage Index

The area wage index described in this section is used to determine adjusted hospital costs as described in the Episode File section. In addition, it is used to adjust the statewide rate to recognize variances in area labor costs.

To calculate each hospital's area wage index, two years of Medicare-audited wage data, as published in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule, are obtained for the most recent available hospital fiscal years. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by CMS for the Medicare program. Consistent with CMS, the cost report references are obtained from the Medicare Provider Manual, Worksheet S3, Part 3, Line 6 for wages and hours.

The following calculations are completed:

- Each hospital's wage costs are brought to a common point in time by multiplying the hospital's fiscal year end costs by inflation factors derived from IHS Global Insight and weighting factors.
- For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
- The cost reports do not differentiate salaries/hours by unit type.
- The wage adjustor is based on a two-year moving average with the most recent year weighted at 60 percent and the second year weighted at 40 percent.
- If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.
- The average wage for each CBSA is calculated with and without hospital reclassifications:
  a) The average wage for each CBSA without reclassifications is determined. The statewide average wage for all hospitals in the state is calculated. Using these data, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index A.
  b) The average wage for each CBSA with reclassifications is determined. Using these data and the statewide average wage for all hospitals in the state, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index B.
- For hospitals that did not reclassify:
  - If area wage index A is greater than one percent variation from its area wage index B, area wage index A will be used. Otherwise, area wage index B will be used.
- For hospitals that reclassified, area wage index B will be used.
- The state will apply a rural floor whereby no hospital will have an area wage index less than the rural index.

Only the labor share of the statewide rate is adjusted by the area wage index using the following formula:

Medical/Surgical Area Wage Index Adjusted Rate = 0.70 x Area Wage Index + 0.30

2.3.A.5. COST-TO-CHARGE RATIO

The operating cost-to-charge ratios described in this section are used to determine adjusted hospital costs as described in the Episode File section. In addition, they are used to reimburse hospitals for transplant services, cost outliers and low-day outliers. The operating cost-to-charge ratios are updated annually on October 1 by rolling the data forward by one year.

The most recent two years of cost report data for hospitals are used to calculate hospital-specific operating cost-to-charge ratios. For example, for the one year rate that begins on October 1, 2015, data from cost reports with fiscal years ending between October 1, 2011 and September 30, 2013 are used. Data for the most recent year are weighted at 60 percent while data for the second previous year are weighted at 40 percent. Costs and charges for both FFS and managed care are combined so that a weighted operating cost-to-charge ratio is developed. Cost and charge data are inflated to a common point in time using inflation factors from IHS Global Insight. The cost-to-charge ratio will not exceed 1.0.

If two or more hospitals merge and are operating as a single hospital, a cost-to-charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger.

The operating cost-to-charge ratios are published on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.A.6. SPECIAL CIRCUMSTANCES

Normal reimbursement for a medical/surgical inpatient hospital stay is equal to the applicable statewide rate multiplied by the DRG weight. However, for the following special circumstances, different reimbursement methodologies apply.

High Cost Outliers	For unusually high cost stays, the State will use a special reimbursement methodology. An episode is a high cost outlier when costs (charges X the hospital's operating cost-to-charge ratio) exceed the computed cost threshold. Transplant claims cannot qualify as a high cost outlier. Reimbursement for cost outliers is dependent upon the cost threshold. The cost threshold is the greater of: ▪ 2 x Hospital DRG Rate x Relative Weight (twice the regular payment for a transfer paid on a per day basis for episodes getting less than a full DRG); or

	▪ $35,000. Cost outliers are reimbursed according to the following formula: (Hospital DRG Rate x Relative Weight) + [(Charges x Operating Cost-to-Charge Ratio) - (Cost Threshold)] x 85 percent) = Reimbursement for Cost Outlier Claim
Low Day Outliers	For services where the length of stay is less than the published low day threshold, reimbursement is charges multiplied by the individual hospital's operating cost-to-charge ratio, not to exceed the full DRG payment. Length of stay is calculated using the From and To dates of service. The specific low day outlier threshold for each DRG is listed on the MDHHS website. (Refer to the Directory Appendix for website information.)
Transfers	Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again. • **Payment to the Transferring Hospital** Except in the cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the patient's stay, not to exceed the appropriate full DRG payment, plus an outlier payment, if appropriate. • **Payment to the Receiving Hospital** If the patient is discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate. Reimbursement is based on discharge in the following situations. If the patient: ➢ Is formally released from the hospital, or ➢ Is transferred to home health services, or ➢ Dies while hospitalized, or ➢ Leaves the hospital against medical advice, or ➢ Is transferred to a long-term care facility. If the patient is transferred again, the hospital is paid as a transferring hospital.
Readmissions	Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes. If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode. Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.

<table>
<tr><td>Transplant Services</td><td>Transplant services are paid using the following formula:

Hospital Charges x Hospital Operating Cost-to-Charge Ratio = Hospital Payment

Transplant services are defined as claims which fall under the following DRGs:

<table>
<tr><th>DRG</th><th>Description</th></tr>
<tr><td>001x</td><td>Liver Transplant and/or Intestinal Transplant</td></tr>
<tr><td>002x</td><td>Heart and/or Lung Transplant</td></tr>
<tr><td>006x</td><td>Pancreas Transplant</td></tr>
<tr><td>440x</td><td>Kidney Transplant</td></tr>
</table>

Organ acquisition within these DRGs is billed at acquisition cost and is reimbursed at 100% of acquisition cost.</td></tr>
<tr><td>Hospitals Outside Michigan</td><td>Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide rate multiplied by an area wage index of 1.0. All other reimbursement policies apply.

Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital's chief financial officer must submit, and the Behavioral and Physical Health and Aging Services Administration (BPHASA) must accept, documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.</td></tr>
<tr><td>New Hospitals</td><td>A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital rates or one which was not enrolled in the Medicaid program when hospital rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG rate for new general hospitals is the statewide rate multiplied by the applicable area wage index.</td></tr>
</table>

Long-Acting Reversible Contraception	Long Acting Reversible Contraceptives (LARCs) provided in the inpatient hospital setting immediately postpartum are excluded from the DRG payment. An additional payment for the LARC device will be made to a hospital when a LARC is provided immediately postpartum. Practitioners will receive payment for their professional services related to the immediate postpartum LARC insertion procedure when billed separately from the professional global obstetric procedure codes and the hospital facility. Costs associated with a LARC device are to be billed separately from the inpatient visit using the Medicaid fee schedule (insertion and device).
Rapid Whole Genome Sequencing	rWGS provided in the inpatient hospital setting prior to discharge is excluded from the DRG payment. An additional payment for the rWGS testing will be made to a hospital when clinical criteria are met and MDHHS authorization is obtained. Costs associated with the rWGS testing are to be billed separately from the inpatient visit using the 837P or CMS-1500 Professional claim format and are reimbursed according to the Medicaid laboratory fee screen.
Spinraza (Nusinersen)	Spinraza (Nusinersen) provided in the inpatient hospital setting is excluded from the DRG payment. An additional payment for medically necessary Spinraza will be made to a hospital when established clinical criteria is met. Costs associated with Spinraza are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid fee schedule.
Outcomes-Based Contract Arrangements	Separate payment for drugs and therapeutics under an outcomes-based contract arrangement will be made to a hospital when established clinical criteria is met. Costs associated with these drugs and therapeutics are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid fee schedule. Drugs and therapeutics that are carved out of the DRG will be published and maintained on the MDHHS billing and reimbursement webpage for Inpatient Hospitals. (Refer to the Directory Appendix for website information.)

2.3.B. Reimbursement for Long Term Acute Care Hospitals (LTACHs) and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units

Episodes of care for LTACHs and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units will be reimbursed using a statewide per diem rate.

2.3.B.1. Description of LTACH and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units Episode File

The episode file is comprised of the underlying data used to calculate the statewide per diem rates. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children's Special Health Care Services FFS paid claims and managed care encounters.

The data is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid payment are included.)
- Eliminate episodes without any charges or days.
- Eliminate episodes with a zero dollar Medicaid liability.

- Limit episodes to those from Michigan hospitals (provided that hospital cost report data is available).
- Limit episodes to those with a valid discharge status.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the operating cost-to-charge ratio for the hospital. (Refer to the Cost-to-Charge section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital. To determine a statewide per diem base rate:

- Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- Recognize area cost differences by dividing the costs for each hospital by an area wage index. (Refer to the Area Wage Index section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)
- Calculate the statewide operating rate (by provider type). A separate operating rate will be calculated for LTACHs and for Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units. This is a weighted mean of all hospitals' individual rates.
- The per diem rate for each provider type is the weighted mean adjusted by the area wage index specific to the hospital.

2.3.B.2. LTACH and Freestanding Rehabilitation Hospitals/ Distinct Part Rehabilitation Units Outside of Michigan

LTACHS, freestanding rehabilitation hospitals, and distinct part rehabilitations units not located in Michigan are reimbursed using the per diem rate applicable to their provider type.

2.3.B.3. New LTACHs, Freestanding Rehabilitation Hospitals, and Distinct Part Rehabilitation Units

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request, in writing, that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by BPHASA, whichever is later.

New LTACHs, freestanding hospitals, and distinct part units are reimbursed using the per diem rate applicable to their provider type.

2.3.C. Frequency of Updates

The State will update area wage index, cost to charge ratio, relative weights, 3M™ APR-DRG grouper, DRG rates, and per diem rates on an annual basis.

2.3.D. Mergers

2.3.D.1. General Hospitals

In the event of a merger between two or more hospitals, the DRG rate for the surviving hospital will be computed as follows:

- The statewide rate will be adjusted by applicable area wage index.
- The cost to charge ratios of the hospitals will be combined to create a new cost to charge ratio.

2.3.D.2. LTACHs, Freestanding Psychiatric and Rehabilitation Hospitals/Distinct Part Psychiatric and Rehabilitation Units

In the event of a merger between two or more hospitals, the resulting per diem rate for the surviving hospital will be computed as follows:

- The statewide rate will be adjusted by applicable area wage index.
- The cost to charge ratio of the hospitals will be combined to create a new cost to charge ratio.

2.3.E. Hospital Change of Ownership

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers Chapter of the Medicaid Provider Manual, hospitals are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

SECTION 3 - SPECIAL INPATIENT SITUATIONS

3.1 MEDICARE/MEDICAID CLAIMS

For patients treated in the inpatient setting with either Medicare Part A coverage or Medicare Part B coverage, no reimbursement is made for capital.

Exception: Where a patient is dually eligible for Medicare/Medicaid and their Medicare Part A benefits have exhausted, Medicaid reimburses the hospital for capital.

Prior to final settlement, hospitals must identify claims eligible to receive capital costs as a result of the patient's Medicare Part A benefits being exhausted. A copy of the Medicaid invoice and the Medicaid Remittance Advice (RA) page showing approval must be provided for these claims. The hospital must also provide a copy of the Medicare Explanation of Benefits (EOB) showing that the patient's Part A benefits have been exhausted. Failure by the hospital to provide this information results in these claims being excluded from its final settlement.

For patients with Medicare Part B coverage and no Medicare Part A coverage, the Medicaid payment amount is determined by subtracting the Medicare Part B payment from the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).

For patients with Medicare Part A coverage, the Medicare payment is compared to the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).

- If the Medicare amount is greater, no additional payment is made, even though a coinsurance or deductible amount may be due.
- If the Medicaid amount is greater, the difference is paid, up to a maximum of the Medicare coinsurance and deductible amounts due for the claim. If a beneficiary is in a Medicare Advantage Plan, Medicaid's liability never exceeds that of the beneficiary. In addition, if the provider accepts the payment from the Medicare Advantage Plan as payment in full, Medicaid has no further liability.

3.2 SUBACUTE VENTILATOR-DEPENDENT CARE

Payment for services provided to patients in Subacute Ventilator-Dependent Care Units (SVDCU) is made using a negotiated prospective per diem rate that includes capital and direct medical education costs. The per diem rate is based on cost estimates for the upcoming year. The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG 004X and DRG 005X. The payment rate for patients in subacute ventilator-dependent care units is an all-inclusive facility rate. No additional reimbursement is made for capital or direct medical education costs. These units are not eligible for indigent volume adjustor or indirect medical education adjustor payments.

The provider agrees to maintain separate accounting records for all costs associated with the dedicated ventilator-dependent unit using special procedures and instructions provided by MDHHS.

- Providers must maintain a separate cost center consistent with the requirements of MDHHS for all costs directly associated with the SVDCU, such as salaries, ancillary costs and others. The capital costs and other indirect costs are to be allocated to SVDCU using the method in accordance with Medicaid Long Term Care Cost Reporting requirements.
- SVDCU patient days and discharges must be reported separately under an inpatient cost center identified as SVDCU patient care on the cost report.
- Cost reporting for this separate SVDCU must be consistent for Medicaid and Medicare cost reporting.

3.3 Michigan State-Owned Hospitals

Michigan state-owned hospitals are reimbursed for their services using a prospective per diem rate. Each facility, in aggregate, will not receive payments in excess of the costs it incurs providing services to its Medicaid patients. Reimbursement for Michigan state-owned hospitals is subject to Federal upper payment limits.

SECTION 4 - HOSPITAL REIMBURSEMENT BY MEDICAID HEALTH PLANS

4.1 MEDICAID HEALTH PLAN PAYMENTS TO OUT OF NETWORK HOSPITALS

Medicaid Health Plans are to reimburse out of network medical/surgical hospitals at Medicaid FFS DRG hospital prices. MHPs are to reimburse out of network freestanding rehabilitation hospitals and distinct-part rehabilitation units at Medicaid per diem rates. MHPs are to use the DRG Grouper in use by Medicaid for the date of service to process out of network inpatient hospital claims and assign DRGs to determine relative weights, outliers, and average lengths of stay.

The hospital's Medicaid operating cost to charge ratios in effect for the date of service are to be used in the calculation of low day outliers, cost outliers, and organ transplants. Refer to the Special Circumstances subsection of this Appendix for information about MDHHS reimbursement for Transplant Services.

In addition to the DRG or per diem payment, a separate capital payment must be made for each out of network medical/surgical admission at the per discharge rate. A separate capital payment must also be made for each day a patient receives care in an out of network freestanding rehabilitation hospital and distinct-part rehabilitation unit. Capital payments for acute care and rehabilitation units and for freestanding hospitals will be updated annually.

4.2 TERMS OF SERVICE AND PAYMENT BETWEEN NONCONTRACTING HOSPITALS AND MHPS

To assure that all Medicaid beneficiaries have universal access to medically necessary covered hospital services, MDHHS, in cooperation with Medicaid enrolled hospitals and MHPs, developed a set of mutually identified obligations and a process to assure these obligations are met.

To acknowledge the responsibilities of hospitals and MHPs in noncontracting circumstances, a Hospital Access Agreement and MHP Obligations document were developed. Each Hospital is encouraged to execute the Hospital Access Agreement. Although execution of this Agreement is voluntary on the part of each Hospital, MDHHS expects that substantially all Hospitals will sign and return the Agreement. Signed copies of the Hospital Access Agreement are to be submitted by hospitals to MDHHS. The Hospital Access Agreement is not a contract with a MHP.

Refer to the Medicaid Health Plans Chapter of this manual for additional information about noncontracting hospitals and MHPs.

4.2.A. DEFINITIONS

The definitions of terms used in this section and in the Hospital Access Agreement, MHP Obligations, and Rapid Dispute Resolution Process (RDRP) are as follows:

Authorization or Prior Authorization (PA)	Documented approval by a MHP for the medical services rendered to an enrollee by a hospital based on clinical information provided to the MHP and pursuant to the terms set forth in this chapter.
Beneficiary	An individual who has been determined eligible for Medicaid.

Certificate of Coverage	Certificate of Coverage means the written document approved by the Department of Insurance and Financial Services (DIFS) which explains the scope of benefits, limitations of coverage, and exclusions governing the enrollee's health care benefit coverage pursuant to the MHP's Medicaid Contract with the State of Michigan.
Clean Claims	Clean Claims as defined in PA 187 of 2000, being MCL 400.111i and OFIR bulletin 2000/09.
Covered Services	All required services for Medicaid enrollees as defined by: ▪ Section 400.105 of the Michigan Compiled Laws, ▪ Title XIX of the federal Social Security Act, 42 USC 1395 et. seq., ▪ MDHHS Program Manuals and Bulletins, ▪ The contract between MHPs and the Michigan Department of Technology, Management & Budget for services rendered to enrollees, and ▪ The Certificate of Coverage.
Emergency Medical Condition	Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: ▪ Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or their unborn child; ▪ Serious impairment to bodily functions; or ▪ Serious dysfunction of any bodily organ or part.
EMTALA	The Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd that requires a hospital to perform a medical screening examination of any individual presenting in its emergency department (ED) to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Enrollee	A Medicaid-eligible beneficiary who is enrolled in a MHP and who is either eligible at the time of service or determined retroactively eligible.
Hospital	The licensed entity that executed the Hospital Access Agreement included below and which has the inpatient capacity that is necessary to provide covered services.
Medicaid Health Plan	A Medicaid managed care plan that provides medical assistance through the delivery of covered services to beneficiaries and that holds a Medicaid Contract with the State of Michigan.
Medicaid Rates	The entire amount payable by MDHHS to hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in MHPs. It includes, without limitation, DRG payments, per diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. Any other available resources, such as Medicare or other insurances, reduce the amount payable.

Noncovered Service	A medical or health care service that is: ▪ Not covered by Medicaid, ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage, ▪ Provided before or after a beneficiary is an enrollee in a MHP, or ▪ A non-emergency service for which the Hospital did not secure PA.
Rapid Dispute Resolution Process	The process implemented by MDHHS to administer and resolve claim disputes according to the terms set forth in the Rapid Dispute Resolution Process (RDRP).

4.2.B. Hospital Access Agreement

The Hospital Access Agreement (HAA) is between MDHHS and the hospital, and applies when a hospital provides services to Medicaid beneficiaries who are enrolled in a MHP with which the hospital does not have a contract. Where a hospital and MHP have a contract, the terms of that contract govern each relationship, and the HAA does not apply. When a hospital and a MHP have a limited services contract, the HAA applies for all covered services outside the scope of the limited services contract. Since the HAA is not a contract between a hospital and MHP, it is expected that health plans will continue to use network-contracted providers where appropriate.

The HAA is based on the following principles:

- It is intended to provide access for all covered services that are available at a hospital for all Medicaid enrolled beneficiaries, and to provide for the payment and billing policies and procedures for those services where the hospital and the enrollee's MHP have not entered into a contract.
- MDHHS, hospitals, and MHPs believe that it is essential to encourage contracting as the preferred relationship between health plans and hospitals, and to preserve the freedom of contract between hospitals and MHPs.
- The hospital will be entitled to payment by a health plan for all covered services provided in accordance with the HAA at Medicaid rates.
- In the event a MHP does not make the payment to a hospital as required under the HAA, MDHHS will deduct the unpaid amount from future health plan capitation payments and make such payment to the hospital in accordance with the HAA.
- MDHHS requires that the contracts between the State and each MHP include a provision that each MHP will comply with the terms of the HAA.

The agreement covers:

- Provision of Covered Services
- Health Plan Payment
- MDHHS Payment

- Authorization Requests - Post Stabilization
- Prior Authorization - Elective Admissions and Services
- Data Coordination
- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly Transfer
- Claims
- Disputed Claims
- Payment
- Enrollee Hold Harmless
- Termination of the Agreement
- Parties to This Agreement
- Governing Law
- Notice of Change

A copy of the Hospital Access Agreement is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.3 MHP Obligations

The MDHHS contract with each MHP contains an amendment regarding the MHP's obligation to a hospital when the MHP does not have a contract with the hospital to provide services to the MHP's Medicaid beneficiaries and where the hospital has signed a Hospital Access Agreement with MDHHS.

The MHP makes efforts to utilize network-contracted services where appropriate.

The contract amendment specifies MHP requirements for:

- Timely processing of claims
- Authorization requests - post stabilization
- Disputed claims
- Claim payment
- Claims data coordination
- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly transfers
- Dispute Resolution

A copy of the MHP contract and the Health Plan Obligation Amendment are available on the MDHHS website.

4.4 Disputed Claims

A Rapid Dispute Resolution Process (RDRP) was developed to provide a method for hospitals and MHPs to resolve disputed claims when the parties cannot reach an agreement. The process is included with the Hospital Access Agreement.

SECTION 5 – CAPITAL

Effective January 1, 2015, MDHHS will reimburse inpatient capital using a hospital-specific prospective rate. A prospective per-discharge amount will be calculated for medical/surgical hospitals, including critical access hospitals and children's hospitals. Freestanding rehabilitation hospitals and distinct part rehabilitation units will be reimbursed a prospective per diem capital rate. Transfer claims will not receive a prospective capital payment.

When calculating the prospective capital rates, data from the second previous state fiscal year will be used. For example, to calculate January 1, 2015 capital rates, data from cost reports with fiscal years that end between October 1, 2012 and September 30, 2013 will be used. Fee-for-Service (FFS) data will be used to calculate capital amounts.

The capital amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92. The sum of routine and ancillary cost for FFS is then divided by the medical/surgical FFS discharges for the same period to calculate the hospital-specific prospective per discharge rate for Managed Care Organizations (MCOs) and FFS.

The capital amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92. The sum of the routine and ancillary cost for FFS is then divided by the FFS rehabilitation Medicaid days for the same period to calculate the hospital-specific prospective per diem rate for MCOs and FFS.

Current occupancy limits will remain when the hospital specific prospective capital rates are developed. Capital amounts will be set annually. Capital amounts may be adjusted due to significant changes in capital costs that are not reflected in the cost report utilized to set the rate. Hospitals may request a capital rate adjustment by submitting a written request to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

Hospitals may continue to receive capital interim payments, but only if they receive Medicaid interim payments. Otherwise, the hospital will receive its prospective rate when the inpatient claim is adjudicated. If the hospital receives capital interim payments, amounts will be reconciled 15 months after the hospital's fiscal year ends, and again at final settlement 27 months after the hospital's fiscal year ends.

5.1 DISTINCT PART REHABILITATION UNITS AND FREESTANDING REHABILITATION HOSPITALS

For distinct part rehabilitation units and freestanding rehabilitation hospitals, a separate inpatient capital rate will be calculated. The sum of the Medicaid fee-for-service (FFS) and managed care organization (MCO) routine and ancillary costs are divided by the FFS and MCO rehabilitation Medicaid days to calculate the hospital-specific prospective per diem rate.

5.2 Medical/Surgical Hospitals

For medical/surgical hospitals, a separate inpatient capital rate will be calculated. The sum of the Medicaid FFS and MCO routine and ancillary costs are divided by the medical/surgical FFS and MCO discharges to calculate the hospital-specific prospective per discharge rate.

5.3 Net Licensed Beds

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined below. Net licensed bed days are:

Total Licensed Bed Days - Rural Banked Bed Days

A hospital may apply for a reduction in net licensed bed days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project is required.

Occupancy is:

Total Inpatient Days (Including Nursery Days)/Net Licensed Bed Days

5.3.A. Sole Community Provider Eligible Hospitals

If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

5.3.B. Rural Hospitals

If a hospital is located in a rural area, as defined below, capital reimbursement is limited if occupancy in the hospital is less than 60 percent during the hospital's fiscal year. A hospital is considered a rural hospital if it is located outside a city of 40,000 or more people by a distance of 10 miles or more (U.S. Census Bureau population data is used). For hospitals with occupancy less than 60 percent, the Medicaid reimbursement for capital is:

(Occupancy/0.6) x Medicaid Share of Capital

If occupancy is at least 60 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.

5.3.C. Other Hospitals

If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement is limited if occupancy in the hospital is less than 75 percent

during the hospital's fiscal year. For hospitals with occupancy less than 75 percent, the Medicaid reimbursement for capital is:

(Occupancy/.75) x Medicaid Share of Capital

If occupancy is at least 75 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.

5.3.D. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan receive a per case add-on amount to cover capital cost.

Freestanding rehabilitation hospitals and distinct part rehabilitation units of hospitals not located in Michigan receive a per diem add-on amount to cover capital cost.

The add-on amounts are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.

SECTION 6 - MEDICAID INTERIM PAYMENTS

Medicaid Interim Payments (MIPs) are available on a voluntary basis to all inpatient hospitals. MIPs are paid on a monthly schedule (12 payments per year).

For hospitals electing MIP, at the beginning of each hospital's fiscal year, annual program liabilities are set for Title XIX and Title V. Separate amounts are computed for each of a hospital's inpatient units (e.g., acute care and rehabilitation).

6.1 DRG

6.1.A. TITLE XIX GROSS PROGRAM LIABILITY

If DRG-reimbursed, Title XIX calculation of gross program liability is as follows:

- Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Calculated Outlier Amount) + (Capital Rate Per Discharge x Discharge Count).
- Discharges are from the four most recently filed Quarterly Cost Reports, less Outlier Count from MDHHS paid claims files.
- Case mix is a hospital specific value and is drawn from MDHHS paid claims files.
- Gross Liability is reduced by estimated other insurance and patient pay amounts.

6.1.B. TITLE V GROSS PROGRAM LIABILITY

If DRG-reimbursed, Title V calculation of gross program liability is as follows:

- Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Capital Rate Per Discharge x Discharge Count).
- Discharges are from the four most recently filed Quarterly Cost Reports.
- Case mix is a hospital specific value and is drawn from MDHHS paid claims files.
- Gross liability is reduced by estimated other insurance and patient pay amounts.

6.2 PER DIEM

If per diem reimbursed, calculation of gross program liability is as follows:

- Gross Liability = (Days Count x Per Diem) + (Days Count x Capital Rate Per Diem).
- Days are from the four most recently filed Quarterly Cost Reports.
- Gross liability is reduced by estimated other insurance and patient pay amounts.

6.3 Limits

For both DRG and per diem reimbursed hospitals/units, the MIP amount is based on a percentage of inpatient charges approved to inpatient charges filed from the prior year. Further, the MIP amount is limited based on application of a charge ceiling.

6.4 Reconciliation

An initial MIP reconciliation is done for operating costs only. Fifteen months after a hospital's fiscal year ends, reconciliation is done to compare the amount paid by MDHHS to the claims approved amount for the fiscal year reviewed.

Capital cost settlements use filed Medicaid Cost Reports to complete a hospital desk review and settlement prior to issuing a Notice of Program Reimbursement. MDHHS does not wait for Medicare to complete its audit of a hospital's cost report before MDHHS does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements and corresponding final reconciliations are not calculated earlier than 27 months after the end of a hospital's fiscal year end.

6.5 Data Corrections

MIP is an estimate of the amount due a provider in the interim. There is no appeal process. If there is a calculation mistake, the hospital must notify the MDHHS HCRD in writing. (Refer to the Directory Appendix for contact information.)

6.6 Monitoring

Hospitals that wish to receive MIPs must file Quarterly Cost Reports. MDHHS specifies the format and time frames for the filing of these reports. MIP is monitored based on the quarterly reports submitted by the provider. These reports are due 30 calendar days after the end of the quarter. Hospitals may elect to be removed from MIP and receive payments for claims processed weekly. Hospitals removed from MIP are not allowed to reenter the MIP process. If the MIP payment significantly exceeds the amount approved for two consecutive years, the hospital may be removed from MIP. Hospitals under bankruptcy are automatically removed from MIP and are reimbursed for claims processed through CHAMPS.

SECTION 7 – SPECIAL PAYMENTS

7.1 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Indigent volume data is taken from each hospital's Medicaid Cost Report and from supplemental forms that each hospital must file with its Medicaid Cost Report. Data from the most recently available filed Medicaid Cost Report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and separate adjustors are applied to distinct part psychiatric units and distinct part rehabilitation units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's net hospital charges as reported on the Medicaid Cost Report. Indigent charges are the annual charges for services rendered to patients eligible for payments under Medicaid, CSHCS, MIChild, MOMS, and Healthy Michigan Plan, plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

No Medicare charges and no Medicaid obligation to cover premiums, copayments, coinsurance and/or deductibles for beneficiaries who are dually eligible for both Medicaid and Medicare are to be included as a Medicaid charge for the purpose of calculating the amount of indigent volume to be reported on any line of a hospital's Indigent Volume worksheet. Also excluded are charges for Medicaid patients who have other insurance coverage and for whom the full payment, except for copayment, coinsurance and/or deductible, comes from the insurance payer.

Uncompensated care, bad debt recovery, and/or Hill-Burton offset may be apportioned using the ratio of total inpatient medical-surgical charges to total charges, the ratio of total distinct part rehabilitation unit charges to total charges, the ratio of total distinct part psychiatric unit charges to total charges, and the total of outpatient charges to total charges.

7.1.A. INDIGENT VOLUME DATA AND DISPROPORTIONATE SHARE HOSPITAL ELIGIBILITY FORM [CHANGE MADE 4/1/2025]

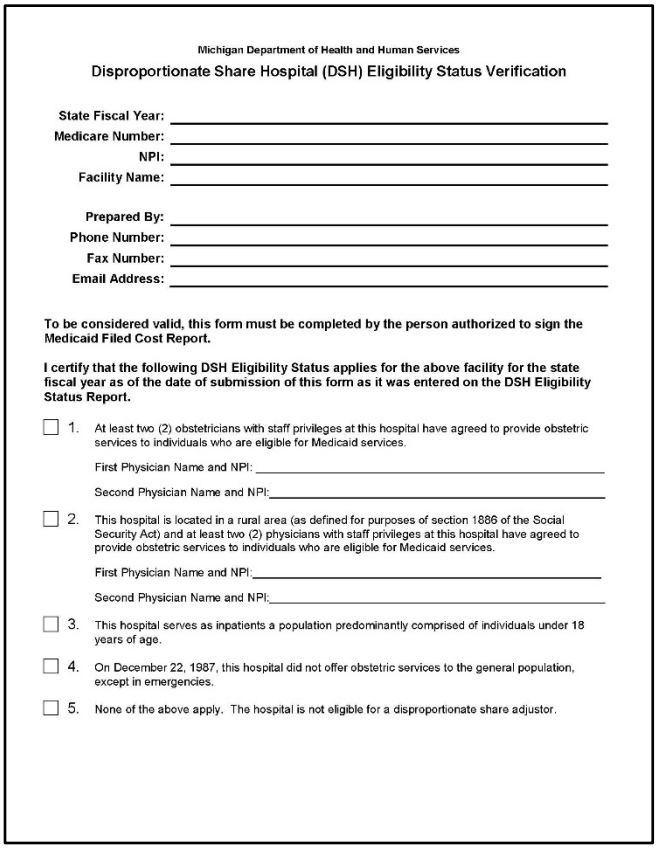
Each hospital must complete the Indigent Volume (IV) worksheet and the Disproportionate Share Hospital (DSH) Eligibility Status Verification form to be eligible for Disproportionate Share Hospital (DSH) funds.

The Indigent Volume (IV) worksheet is to be completed as part of the hospital's annual Medicaid Cost Report and returned to MDHHS. The Medicaid Cost Report will not be accepted without the IV worksheet. Effective state fiscal year 2024, the DSH Eligibility Status Verification form for discontinued DSH pools is not required. **(text added per bulletin MMP 24-56)**

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the four criteria on the Disproportionate Share Hospital (DSH) Eligibility Status Verification form.

The Disproportionate Share Hospital (DSH) Eligibility Status Verification form is to be completed annually and is reported separately from the Medicaid Cost Report.

An example of the form follows.



Michigan Department of Health and Human Services

Disproportionate Share Hospital (DSH) Eligibility Status Verification

State Fiscal Year: _____
Medicare Number: _____
NPI: _____
Facility Name: _____

Prepared By: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

To be considered valid, this form must be completed by the person authorized to sign the Medicaid Filed Cost Report.

I certify that the following DSH Eligibility Status applies for the above facility for the state fiscal year as of the date of submission of this form as it was entered on the DSH Eligibility Status Report.

☐ 1. At least two (2) obstetricians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

First Physician Name and NPI: _____

Second Physician Name and NPI: _____

☐ 2. This hospital is located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and at least two (2) physicians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.

First Physician Name and NPI: _____

Second Physician Name and NPI: _____

☐ 3. This hospital serves as inpatients a population predominantly comprised of individuals under 18 years of age.

☐ 4. On December 22, 1987, this hospital did not offer obstetric services to the general population, except in emergencies.

☐ 5. None of the above apply. The hospital is not eligible for a disproportionate share adjustor.

7.1.B. Medicaid Utilization Rate

In addition to the minimum requirements specified in the form, each hospital must have a Medicaid utilization rate of at least one percent. Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital, including Subproviders)}}{\text{Total Hospital Days (Whole Hospital, including Subproviders)}}$$

Days are taken from filed hospital Medicaid Cost Reports for fiscal years ending during the second previous state fiscal year. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year (e.g., DSH payments for state FY 2021 are calculated using data collected in state FY 2019).

7.2 Regular DSH Payments [Change Made 4/1/2025]

Effective State Plan rate year 2024, the DSH pools and methodology described in the Regular DSH Payments section are discontinued. **(text added per bulletin MMP 24-56)**

7.2.A. $45 Million Pool

Medicaid inpatient DSH payments are made annually in a single distribution, based on charges converted to cost, using the hospital's cost to charge ratio. The payment will be made at the end of the state fiscal year.

Each hospital's indigent volume is taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used for computing DSH payments are the sum of Title XIX charges and Title XIX MCO charges from hospital IV worksheets for cost periods ending during the second previous state fiscal year. Data for cost periods of more or less than one year is proportionately adjusted to one year.

Hospital total cost ratios are taken from hospital cost reporting periods ending during the second previous state fiscal year. If a hospital has more than one cost reporting period ending within this range, data from the two periods are added together and a single ratio is computed. If the ratio is greater than 1.00, a ratio of 1.00 is used.

1. DRG Reimbursed Hospitals ($37,500,000 allocated)

   The DSH payments for DRG reimbursed hospitals are split into two pools.

   A. Hospitals with at least 50 percent IV ($7,300,000). The share of the DSH payment for hospitals with at least 50 percent IV is based on a DSH share computed as follows:

      Title XIX Charges x Operating Ratio x (IV - 0.5)

   B. Hospitals with at least 20 percent IV ($30,200,000). The share of the DSH payment paid to hospitals with at least 20 percent IV is based on the following DSH share amount. This is in addition to the amount from A. above.

      Title XIX Charges x Operating Ratio x (IV - 0.2)

2. Per Diem Reimbursed Hospitals and Units ($7,000,000 allocated)

   The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share based on the following:

   Title XIX Charges x Operating Ratio x (IV - 0.2)

3. Distinct-Part Rehabilitation Units ($500,000 allocated).

   The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share of the following:

   Title XIX Charges x Operating Ratio x (IV - 0.2)

4. For items 1 through 3 above, the determination of the share of the allocated DSH pool is made using the DSH share of the following:

   (Hospital's DSH Share / Σ DSH Shares for the Group) x Allocated DSH Pool

5. The regular DSH payment amount for each hospital is determined by comparing the results of the pool's payment allocation formula at each component of the regular DSH Pool — Diagnosis Related Group (DRG) Reimbursed Hospitals, Per Diem Reimbursed Hospitals and Units and Distinct-Part Rehabilitation Units — to the individual hospital DSH ceiling. Any amount not paid to a hospital because of its DSH ceiling is returned to the pool and redistributed using the same formula as the initial distribution, with hospitals over the ceiling removed from the calculation. This process continues until the entire pool is distributed. For the DRG Reimbursed Hospitals component, any funds not exhausted from the 50 percent IV sub pool will be placed into the 20 percent IV sub pool.

7.3 Special DSH Payments [Change Made 4/1/2025]

Effective State Plan rate year 2024, the special DSH pools and methodology described in the Special DSH Payments section are discontinued. **(text added per bulletin MMP 24-56)**

7.3.A. Government Provider DSH Pool

A special pool for non-state government-owned or -operated hospitals will be established and renewed annually. The purpose of the pool is to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs. A historical list of Government Provider pool sizes is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Allocations will be determined based upon non-reimbursed costs certified as public expenditures in accordance with 42 CFR 433.51.

To be eligible for the Government Provider DSH Pool, hospitals must:

- Meet minimum federal requirements for Medicaid DSH payments; and
- Be non-state government-owned or –operated.

Aggregate DSH expenditures will be made in accordance with Section 1923(g)(1)(A) of the Social Security Act. Prior to computing the amount of payment each individual hospital is eligible to receive from this pool, all other DSH and Medicaid payments that the hospital is scheduled to receive will be counted against the hospital's DSH limit.

7.3.B. University with both a College of Allopathic Medicine and a College of Osteopathic Medicine

A separate $3.5 million dollar pool will be created annually. The purpose of the pool is to:

- Assure continued access to medical care for indigents; and
- Increase the efficiency and effectiveness of medical practitioners providing services to Medicaid beneficiaries under managed care.

Only one agreement per year is approved by MDHHS for this purpose. To be eligible for the pool, a hospital must meet the following criteria:

- Meet minimum federal requirements for Medicaid DSH payments; and
- Have in place an approved agreement between itself and a university with both a college of allopathic medicine and a college of osteopathic medicine that specifies all services and activities to be conducted.

This agreement shall not require the hospital to donate money or service to the other party in the agreement.

7.3.C. Outpatient Uncompensated Care DSH Pool

A special pool will be created annually for the purpose of reimbursing hospitals for a portion of their uncompensated care. The Outpatient Uncompensated Care DSH Pool will be split into Small and Rural and Large-Urban components. A historical record of the pool amounts can be found on the MDHHS website. (Refer to the Directory Appendix for website information.) Payments from the pool will be made annually.

Funds will be distributed from the Outpatient Uncompensated Care DSH Pool to all qualifying Privately-Owned or -Operated and Non-State Government-Owned or -Operated DSH eligible hospitals in Michigan. DSH eligibility criteria are specified in the Disproportionate Share Hospital Payments, the Indigent Volume worksheet and Disproportionate Share Hospital Eligibility Form, and the Medicaid Utilization Rate subsections of this chapter. These criteria must be met for a hospital to receive an allocation from any component of the Outpatient Uncompensated Care DSH Pool.

For purposes of distributions from this pool, any DSH hospital located in Michigan with less than 100 acute care beds will be considered a small hospital. Also for purposes of distributions from this pool, any DSH hospital located in a Michigan rural or Micropolitan County will be considered a rural hospital. All hospitals meeting either of these criteria will be eligible to receive a proportional share of the small and rural components of the pool.

For purposes of distributions from this pool, any DSH hospital with 100 or more acute care beds located in an urban Michigan county will be considered a large-urban hospital. Only hospitals meeting both of these criteria will be eligible to receive a proportional share of the large-urban components of the pool. Hospitals meeting only one of these criteria are by definition eligible to receive a proportional share of the small and rural

components of the pool. No hospital is eligible to receive allocations from both the small and rural and the large-urban components of the Outpatient Uncompensated Care DSH Pool.

The determination of the number of acute care beds for a hospital will be based on data reported on hospital Medicaid Cost Reports for hospital fiscal years ending during the second previous state fiscal year. Specifically, data reported on Worksheet S-3, Part 1, Column 2, Line 14 (or comparable lines from succeeding Medicaid Cost Reports) will be assessed to determine the number of total hospital beds. The determination will apply to all components of the Outpatient Uncompensated Care DSH Pool regardless of the state fiscal year from which the DSH funds are drawn.

The distribution of funding from the Outpatient Uncompensated Care DSH Pool will be based on each hospital's proportion of outpatient uncompensated care relative to other hospitals in each component of the pool. The process will be repeated for each component of the pool until the entire pool has been distributed. The process to accomplish this is detailed below.

Beginning in FY 2015, $5,000,000 of the Large-Urban Component of the pool will be distributed to reward and incentivize hospitals providing low cost and high quality Medicaid services. The Medicare Value Based Purchasing (VBP) Adjustment Factor will be obtained annually from the Federal Register. Each hospital's respective payment from the $5,000,000 pool component will be calculated as follows:

- (Hospital's Outpatient Uncompensated DSH Hospital Pool Factor) x (Hospital's VBP Adjustment Factor) = (Hospital's Outpatient Uncompensated DSH Value Adjustment Factor)
- (Hospital Outpatient Uncompensated DSH Value Adjustment Factor)/(∑All Hospital Outpatient Uncompensated DSH Value Adjustment Factors) x (Total Pool Amount) = (Outpatient Uncompensated DSH Value Payment)

1. A Medicaid outpatient payment to charge ratio will be calculated for each hospital as follows:

(Hospital Title XIX Outpatient FFS Payments) / (Hospital Title XIX Outpatient FFS Charges) = (Hospital Title XIX Outpatient Payment to Charge Ratio)

2. Net uncompensated outpatient charges will then be computed for each hospital as follows:

(Hospital Uncompensated Outpatient Charges) – (Hospital Uncompensated Outpatient Payments) = (Net Hospital Uncompensated Outpatient Charges)

3. The computed net hospital uncompensated outpatient charges will be standardized by converting them to a Medicaid fee-for-service payment equivalent. This will be done by multiplying the results of Step 1 by the results of Step 2 as follows:

(Hospital Title XIX Outpatient Payment to Charge Ratio) x (Net Hospital Uncompensated Outpatient Charges) = (Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments)

4. Each hospital's proportion of the pool component being calculated (or hospital pool factor) is determined by dividing their Medicaid fee-for-service payment equivalent by the total of all Medicaid fee-for-service payment equivalents of hospitals in the pool component. This step is expressed as follows:

(Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments) / (∑ of all Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments) = (Outpatient Uncompensated DSH Hospital Pool Factor)

5. Each hospital's respective pool component payment is determined by multiplying their hospital pool factor from Step 4 by the total pool component amount being calculated as follows:

(Outpatient Uncompensated DSH Hospital Pool Factor) x (Outpatient Uncompensated DSH Pool Component Amount) = (Outpatient Uncompensated DSH Hospital Pool Component Payment)

Pool component payments calculated for individual hospitals that are in excess of an individual hospital DSH ceiling will be placed back into that component of the pool. These payments will then be reallocated to the remaining hospitals in that component of the pool which have not exceeded the room available under their individual hospital DSH ceiling. The reallocation will be based on the original five step funding formula specified above. Only hospitals with available DSH ceiling capacity will be included in the relevant portions of the formula. This reallocation process will be repeated as many times as necessary to expend all funds in each component of the pool.

7.4 Calculation of DSH Ceiling

Hospital data utilized to calculate hospital-specific DSH ceilings includes inpatient and outpatient data. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year. Data should be separated by subprovider.

1. DSH Ceiling Financial Elements

- Title XIX Charges – Base year Title XIX charges include Title XIX charges for those beneficiaries enrolled in MHPs and beneficiaries dually enrolled in Title V and Title XIX.
- Title XIX Costs – Multiply total base year Title XIX charges times the hospital's Title XIX cost to charge ratio for the cost reporting period to determine Title XIX Costs. (The cost to charge ratio should be inclusive of capital and medical education costs.)
- Uninsured Charges – Uninsured charges are charges for services provided to beneficiaries who do not have any insurance coverage or for services not covered by the patient's insurance coverage. (Services covered by Medicare and/or Medicaid are not included as uninsured charges.)
- Uninsured Costs – Multiply total base year uninsured charges times the hospital's cost to charge ratio to determine uninsured costs. (The cost to charge ratio should be inclusive of capital and medical education costs.)
- Title XIX Payments – Title XIX Payments made by MDHHS or MHPs for services are included in computing the base year Title XIX payments. (Payments must include capital and medical education payments.)

- Uninsured Payments – Uninsured payments are those made by or on behalf of an individual beneficiary for the services included in computing base year uninsured payments.

The DSH ceiling calculation is:

Title XIX charges x Title XIX cost to charge ratio = Title XIX costs

Uninsured charges x uninsured cost to charge ratio = uninsured costs

Title XIX payments + uninsured payments + pool payments = total payments

Title XIX costs + uninsured costs – total payments = DSH ceiling

The following trend factors will be applied to the financial elements used to calculate hospital DSH ceilings only during the Initial DSH Calculation for each year. These trend factors will not be applied during the DSH Settlement calculations.

- Base Year Cost Inflation – Inflation of base year costs (inpatient and outpatient) is computed using the Global Insight index of inflation for the entire hospital. Hospital costs are inflated from the hospital FYE to the current state FYE. Inflation of payments is computed from the hospital's rate change over time.
- Base Year Utilization Trend – Hospital costs and payments are also adjusted from the state base year to the state current year end by the percentage change in the projected annual average Medicaid enrollment between the two periods.

7.5 Disproportionate Share Hospital (DSH) Process [Change Made 4/1/2025]

Effective State Plan rate year 2024, DSH payments will be limited to the Institute for Mental Diseases (IMD) pool. All other regular and special DSH Pools will be discontinued effective State Plan rate year 2024. **(text added per bulletin MMP 24-56)**

The DSH process is designed to mitigate DSH audit-related recoveries. It is a two-step process that allows hospitals to provide input into the DSH calculations, decline DSH funds, and reduce their DSH ceiling. The two-step DSH process is as follows.

Step 1: Initial DSH Calculation

MDHHS will calculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates as part of its Initial DSH Calculation. Inpatient and outpatient data from the hospital's cost reporting period ending during the second previous state FY will be used for the DSH ceiling, DSH payment and Medicaid utilization rate calculations. The data will be trended to the current FY for DSH ceiling calculation purposes. For example, data from hospital Medicaid Cost Reports with FYs ending between October 1, 2018 and September 30, 2019 will be used to complete the FY 2021 Initial DSH Calculation.

MDHHS will share Initial DSH Calculations with hospitals. Non-IMD hospitals **(revised per bulletin MMP 24-56)** will be able to decline DSH funds following the Initial DSH Calculation findings. If a hospital declines DSH funds during the Initial DSH Calculation step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Initial DSH Calculation step. Upon receipt of this feedback from hospitals, each

hospital's calculated DSH ceiling will be reduced to the requested amount. No hospital will receive a DSH payment in excess of its initial DSH ceiling.

DSH payments will be applied against a hospital's DSH ceiling in the following order:

1. Institutions for Mental Diseases Pool
2. $45 Million Pool
3. Outpatient Uncompensated Care DSH Pool
4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
5. Government Provider DSH Pool (GP DSH Pool)

Step 2: Final DSH Settlement Step

DSH ceilings, DSH payments and Medicaid utilization rates are recalculated during the final DSH settlement step. DSH funds will be reallocated in the following manner:

1. Institutions for Mental Diseases Pool
2. $45 Million Pool
3. Outpatient Uncompensated Care DSH Pool
4. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
5. Government Provider DSH Pool (GP DSH Pool)
6. Unspent funds not applicable to Step 1

MDHHS will recalculate hospital-specific DSH limits, DSH payment allocations and Medicaid utilization rates upon completion of the DSH audit for the applicable DSH year. Inpatient and outpatient cost and payment data utilized from Step 1 will be refreshed to account for any cost report changes that occurred between steps during the cost report acceptance process. DSH limits and Medicaid utilization rates will be calculated using the final DSH audit. No hospital will receive a DSH payment in excess of its audited DSH Settlement limit.

Upon completion of the calculations for the first five pools outlined in the order above, any remaining unspent federal DSH allotment will be distributed through a new pool. The remaining allotment will be distributed to all remaining eligible hospitals proportionately based on their share of remaining audited hospital-specific DSH limit capacity adjusted to exclude the DSH payment amounts hospitals received from the university and GP DSH pools. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH limit capacity or other federal limits. The formulas to distribute these funds are as follows

1. (Eligible Hospital's Remaining Audited DSH Limit Capacity + University DSH Payment Amount + GP DSH Payment Amount) / (∑ of All Eligible Hospitals' Audited Remaining DSH Limit Capacity + University DSH Payment Amount + GP DSH Payment Amount) = (Hospital Pool Factor)
2. (Hospital Pool Factor) X (Pool Amount) = Pool Payment

7.5.A. Distribution of DSH Payments for Merged Hospitals

When two or more hospitals merge, eligibility for DSH payments after the merger is based on the combined Medicaid Cost Report data of the merged hospitals.

7.6 Medicaid Access to Care Initiative

To ensure continued access for Medicaid patients to high quality hospital care, MDHHS established special funding pools. The pool dollar amounts are renewed annually and posted on the MDHHS website.

To keep payments within the Medicare upper payment limits, separate pools are established for privately owned or operated hospitals and nonstate government-owned or operated hospitals for both inpatient and outpatient hospital services. Only hospitals located within Michigan, enrolled in Medicaid, open, treating, and admitting Medicaid FFS and MHP patients 10 days prior to a scheduled payment are eligible to receive distributions from these pools.

7.6.A. Pool Descriptions

7.6.A.1. Privately-Owned or Operated Inpatient Hospital Pool

This inpatient pool is computed based upon the total number of privately owned DRG reimbursed hospitals and distinct part rehabilitation units. Privately owned freestanding rehabilitation hospitals with Medicaid FFS payments also participate in this pool.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all privately owned or operated hospitals and units.

7.6.A.2. Privately-Owned or Operated Outpatient Hospital Pool

This outpatient pool is computed based upon the total number of privately owned outpatient units of DRG reimbursed hospitals and privately owned outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all privately-owned or operated hospitals and units.

7.6.A.3. Nonstate Government-Owned or Operated Inpatient Hospital Pool

This inpatient pool is computed based upon the total number of nonstate government-owned DRG reimbursed hospitals and distinct part rehabilitation units. Nonstate government-owned freestanding rehabilitation hospitals with Medicaid FFS payments participate in this pool also.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid

FFS inpatient payments for all nonstate government-owned or operated hospitals and units.

7.6.A.4. Nonstate Government-Owned or -Operated Outpatient Hospital Pool

This outpatient pool is computed based upon the total number of nonstate government-owned outpatient units of DRG reimbursed hospitals and outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all nonstate government-owned or operated hospitals and units.

7.6.B. Pool Sizes

A historical list of MACI pool sizes is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.6.C. Distributions

The distribution from these pools will supplement hospitals' regular DRG and per diem payments (for rehabilitation units and hospitals) and is not considered part of a hospital's FFS reimbursement. Medicaid payers that normally match MDHHS FFS payments to medical providers are not required to match the distribution payments from these pools as part of their FFS payments.

The MACI pool dollar amounts will be renewed annually. The dollar amounts of the new pools will be based on the calculated gap between the Medicare Upper Payment Limit and Medicaid fee-for-service payments.

7.6.D. Payment Share

The inpatient and outpatient hospital files used to distribute MACI payments will include FFS payments made on behalf of both Medicaid and CSHCS eligible beneficiaries.

7.6.D.1. Inpatient Paid Claims File

To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30th of the following year (e.g., paid claims from FY 2019 paid by June 30, 2020 will be used to calculate the FY 2021 MACI payments). The paid claims file will include all FFS payments made through CHAMPS, including DRG and per diem payments, DRG outlier payments, and claims paid based on a percent of charge. Paid claims will include those with other insurance and patient-pay amounts. Inpatient services will include both acute and rehabilitation services provided through distinct part rehabilitation units, freestanding rehabilitation hospitals, and subacute ventilator-dependent care units. Services paid to LTC providers will not be included, with the

exception of services paid to subacute ventilator-dependent care units with beds licensed as hospital beds. Revenue from licensed hospital beds utilized at less than an acute or rehabilitation level of care will be excluded from the paid claims file, with the exception of revenue from subacute ventilator-dependent care beds licensed as hospital beds. Payments made outside CHAMPS, such as capital, graduate medical education (GME), and disproportionate share hospital (DSH), will not be included in the paid claims file used to distribute the MACI hospital pools.

7.6.D.2. Outpatient Distribution Data

To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30 of the following fiscal year (e.g., paid claims from FY 2014 will be used to calculate payments in FY 2016 with claims limited to those paid by June 30, 2015). The paid claims file will include all Medicaid FFS payments made for both Medicaid and dual CSHCS eligible beneficiaries through the CHAMPS System. Outpatient services will include both acute and rehabilitation services. Payments made outside CHAMPS, such as capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the payments used to distribute the MACI pools.

7.6.E. Allocation of Pools

MACI distributions are made prospectively based on historical data. Eligible hospitals will share proportionately from each pool based upon a hospital's total paid claims divided by the total Medicaid paid claims for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes or is determined ineligible to receive distributions from a pool, its MACI distribution will be redistributed to the remaining eligible hospitals based on the original distribution formula. In the event the MACI distributions would result in aggregate Medicaid payments exceeding the UPL, the size of the pool(s) will be reduced to bring the aggregate Medicaid payments within the UPL.

7.6.F. Limits to Individual Hospitals

Total Medicaid payments are limited by federal regulation to a hospital's charges for inpatient services and by state policy to the lower of charges or costs for outpatient services. These limits apply by hospital fiscal year for FFS reimbursed services. Hospitals may elect to receive less (but not more) than their calculated quarterly MACI payment. The amount by which a hospital elects to reduce its payment will be redistributed to the remaining eligible hospitals based on the original distribution formula until the respective MACI pools are empty. All MACI payments are final. If charge/cost limits are exceeded, the amounts in excess of the limits will be recovered from hospitals at the time of final settlement. Any funds recovered from hospitals at final settlement will not be redistributed.

Prior to the first quarterly MACI payment for each state fiscal year, each hospital will be notified of the amount of its calculated quarterly MACI payments. A hospital electing to reduce a portion of any MACI payment to avoid exceeding charge/cost limits must inform the state of the amount to be reduced by no later than two weeks prior to the scheduled payment date.

7.6.G. Payment Schedule

MACI payments are made within 45 days of the beginning of each quarter. Quarterly payments are made in four equal installments based on the annual amount each hospital is eligible to receive. However, if a hospital elects to reduce a portion of any MACI payment to avoid exceeding charge/cost limits, then that payment is reduced to the amount specified by the hospital.

7.7 Special Payment Adjustments

Effective August 1, 2007 and each subsequent fiscal year, MDHHS is directed to reduce hospital payments in each respective fiscal year. These reductions are pursuant to the budgetary savings included in the MDHHS annual appropriations act. The amount of the reductions and the distribution by hospital are posted on the MDHHS website. (Refer to the Directory Appendix for website information.) The calculation of the reductions by hospital is described below.

A calculated share of the total annual reductions will be assessed to all hospitals and units operating and enrolled in the Medicaid program on the date the reductions are processed. A hospital's annual reduction will be based on its inpatient hospital paid claims for hospital admissions from October 1 to September 30 of the second previous fiscal year. (The same paid claims file will be used to calculate the hospital MACI payments and the reductions for the fiscal year.) Paid claims include Title V, Title XIX, and Title V/XIX inpatient hospital claims. A hospital's share of the annual reductions is calculated by dividing the total of its paid claims by the total of the paid claims for all affected hospitals times the total amount of funds to be recovered.

Merged hospitals will have their reductions combined. Reductions will be taken from the surviving hospital. Should a hospital or distinct part unit close prior to the end of the fiscal year, its reduction will become part of the hospital's final settlement.

Each hospital's share of the reductions will be made by gross adjustments to the hospital's inpatient provider NPI number. Recoveries will be taken from the hospital's payments until the reductions are complete.

7.8 Rural Access Pool

The Rural Access Pool (RAP) is a pool for hospitals that provide Medicaid services to low-income rural residents and will be created and renewed annually. Effective state FY 2021, eligibility for RAP is limited to non-critical access hospitals. To be eligible for this pool, hospitals must be categorized by CMS as a sole community hospital, or meet both of the following criteria:

- A hospital must have 50 or fewer staffed beds. MDHHS will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid Cost Report with a FY ending between October 1, 2010 and September 30, 2011 by the number of days covered in the Medicaid Cost Report; and
- A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census.

Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient and outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous FY. (Example: To calculate the FY 2014 pool, hospital Medicaid Cost Reports with FYs ending between 10/1/2011 and 9/30/2012 will be used.) The following gross Medicaid payments from this Medicaid Cost Report period will be applied against cost to determine unreimbursed costs: operating, capital, graduate medical education (GME), executive order reductions, and Medicaid Access to Care Initiative (MACI). Payments from this pool will be issued quarterly in four equal installments based on the total amount the hospital is eligible to receive.

In the aggregate, MDHHS will reimburse hospitals up to the maximum allowable under the federal upper payment limits for inpatient and outpatient services provided to Medicaid beneficiaries. To keep total Medicaid Fee-For-Service payments to hospitals within the federal upper payment limits, MDHHS will reduce the size of the corresponding FY MACI pool each year by the amount of the RAP.

Payments made from the RAP will be applied against hospitals' inpatient and outpatient settlement limits. Funds paid in excess of these limits will be recovered during settlement, and the federal share returned to the federal government.

SECTION 8 - GRADUATE MEDICAL EDUCATION

8.1 SERVICE OF TEACHING PHYSICIANS

Medicaid uses the Medicare Principles of Reimbursement to determine Medicaid allowable costs in the hospital setting. The administrative costs associated with teaching physician services as well as payment for direct patient care services provided by an intern, resident, or fellow in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by Medicare.

Teaching institutions and teaching physicians within those institutions must abide by the CMS physician guidelines which explain when services provided in a teaching setting can be billed to Medicaid on a FFS basis or must be reported as allowable medical education costs on the hospital's cost report. The most recent guidelines for when the program may be billed directly are found in 42 CFR §415.

The guidelines require the presence of the teaching physician during the key portion of the performance of a service in which a resident is involved for which payment is sought by the teaching physician (or the hospital on behalf of the physician). The medical record must fully support the physician presence and participation in the service provided. There are exceptions and other considerations that may apply. Consult the full text of the guidelines to be sure you are in compliance for both Medicare and Medicaid.

Medicaid covers preventative medicine services that Medicare does not cover. For Medicaid, preventative medicine evaluation and management services are identified by procedure codes 99381 through 99397. These preventative medicine services may be provided without the presence of the teaching physician as long as all other requirements for the "presence" exception for E/M services furnished in certain primary care centers are met. Follow-up for any abnormal findings during a preventative medicine visit is subject to the teaching physician guidelines for all E/M services.

8.2 DISTRIBUTION OF GME FUNDS

Distribution of graduate medical education funds is calculated annually for three formula pools: the Dental and Podiatry, the GME Funds and the Primary Care. In order to receive funds for GME, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments are made only to hospitals that provide requested information by the dates required.

Only intern and resident full time equivalents (FTEs) in approved programs as specified in Federal Regulations (see 42 CFR §413.75-83) are eligible for inclusion in the data used to calculate the distribution of the Dental and Podiatry, the GME Funds and the Primary Care Pools.

- To obtain an average FTE payment for dental and podiatry residents, the GME liability for hospitals operating dental and podiatry residency programs only are summed. The summed total of these liabilities is divided by the total number of dental and podiatry FTEs as reported by the same hospitals and from the same filed cost reports that the GME liability data is drawn. The product is an average dental and podiatry FTE payment that is made to all hospitals reporting these FTEs.
- Annually, each hospital reporting dental and podiatry FTEs is reimbursed the average dental and podiatry FTE payment, as calculated above, for each dental and podiatry FTE it reports. Data for each hospital's dental and podiatry FTE count is drawn from the hospital cost report (Worksheet

E-4, Title XVIII, Line 10, Column 2). If the cost report is changed, equivalent data is used. Dental and podiatry FTEs are drawn from hospital cost reports for the same state fiscal year that FTEs are drawn to distribute the GME Funds and the Primary Care Pools.

- The dental and podiatry FTE payments made to all hospitals are summed and the total is deducted from the GME Funds Pool before any other distributions are made from this pool.
- Once the dental and podiatry FTE payments have been deducted, the remaining funds in the GME Funds Pool are distributed as described later in this section.
- Each hospital's dental and podiatry FTE count and the total dollar amount allocated to pay hospitals for dental and podiatry FTEs is updated annually. The average dental and podiatry FTE dollar payment is not. The average dental and podiatry FTE dollar payment is adjusted only when the GME Funds and the Primary Care Pools are adjusted. Any adjustment to the average dental and podiatry FTE dollar payment is proportional to the changes in these two pools.

To distribute funds from the GME Funds and the Primary Care Pools, data is drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the unweighted FTE count is used (Worksheet E-4, Title XVIII, Line 6) + (Worksheet E-4, Title XVIII, Line 15.01). For the Primary Care Pool, the weighted FTE count for primary care physicians is used (Worksheet E-4, Title XVIII, Line 8, Column 1) + (Worksheet E-4, Title XVIII, Line 15.00). If the cost report is changed, equivalent data is used.

Both the hospital and its residency programs must be operating during the funding period in order to receive GME funds. Hospitals must notify MDHHS in writing at least 30 days prior to the termination date of any of its residency programs. Funds distributed to ineligible hospitals are subject to recovery.

GME payments to hospitals that merge are combined, provided that the surviving hospital continues to operate all residency programs that the pre-merger hospitals operated. The surviving hospital must notify MDHHS within 30 calendar days after the merger is completed of any reductions or terminations to its residency programs. The GME payments to the surviving hospital are reduced proportionately to the reduction in its GME programs. Overpayments to surviving hospitals based on reductions in GME programs are subject to recovery.

8.3 GME Funds Pool

Adjustments made to the amount of the GME Funds Pool due to legislative action or executive order are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each eligible hospital's share of the GME Funds Pool, the following formulas are used:

FTEs x Case Mix x (Hospital's Title V & Title XIX Days / Hospital's Total Days) = Adjusted FTEs
Pool Size x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution

8.4 Primary Care Pool

Adjustments made to the amount of the Primary Care Pool due to legislative action or executive order are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each hospital's share of the Primary Care Pool, the following formula is used:

FTEs x (Hospital's Title V & Title XIX Outpatient Charges/Hospital's Total Charges) = Adjusted FTEs
Pool Size x (Adjusted FTEs / Σ Adjusted FTEs) = Hospital's Distribution

8.5 Definitions/Notes

Title V & Title XIX Days	Includes FFS days. Days include those from distinct-part psychiatric and distinct-part rehabilitation units.
Title V & Title XIX Outpatient Charges	Includes FFS outpatient charges. Charges include those from distinct-part psychiatric units.
# of Hospital Eligible Resident FTEs	Number of Hospital Eligible Resident FTEs for the GME Funds and the Primary Care Pools FTE data is drawn from hospital cost reports as indicated above.
Hospital's Non-Traditional Case Mix	The sum of the hospital's payments for all Medicaid admissions divided by the number of Medicaid admissions during the period covered. This figure is then divided by the hospital's price or rate.

8.6 Payment Schedule

Payments from the GME Funds and the Primary Care Pools will be made quarterly in four equal payments. Payments from the Dental and Podiatry Pool will be made once annually.

8.7 GME Innovations Agreements

8.7.A. GME Innovations Hospital Program

GME Innovations Agreements support innovative GME programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups. Current single state agency agreements with innovative hospital GME programs include:

- Detroit Receiving Hospital for $8,929,800 annually;
- Hurley Medical Center for $2,018,078 in FY 2018 and $4,381,078 in FY 2019 and future years;
- Pine Rest Christian Mental Health Services for $3,960,000 in FY 17, $6,336,000 in FY 18, and $7,603,200 in FY 19 and future years.

MDHHS will approve three agreements statewide each fiscal year. To be eligible for the pool, a hospital must meet the following criteria:

- Be a Michigan Medicaid enrolled provider.
- Have in place an approved agreement between itself, a university psychiatric residency training program, and one or more community mental health services programs to provide accredited psychiatric residency training.
- Provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

8.7.B. GME Innovations Sponsoring Institution Program

The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME Programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups.

The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME programs that meet the requirements below. This includes sponsoring institutions whose primary purpose is to provide educational programs and/or health care services. A sponsoring institution assumes the financial and academic responsibility for a GME program.

The single state agency will approve one (1) agreement statewide each Fiscal Year (FY). This agreement will be with Authority Health for $2.8 million for FY 2017 and $3.1 million for FY 2018 and subsequent years. If GME distributions exceed the expenses incurred by the sponsoring institution in residency training, the size of the agreement will be reduced to bring these elements into alignment. To be eligible for the GME Innovations Program without a hospital partner, an organization must meet the following criteria:

- The organization must possess appropriate accreditation credentials.
- The organization must meet the requirements associated with receiving Medicaid payments.
- The organization must have an approved agreement with a sponsoring institution, a university psychiatric residency training program, and one or more community mental health services programs to provide accredited psychiatric residency training.
- The organization must provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

8.7.C. GME Innovations Michigan Doctors (MIDocs) Program

The GME MIDocs program supports the expansion of residencies and subsequent retention efforts for approved high need specialties in underserved areas of the state where current and future physician shortages undermine the health and well-being of Medicaid beneficiaries. The MIDocs program offers physician training in integrated and

patient-centered care for underserved populations that will further the state's Medicaid quality goals. To be eligible for MIDocs GME funding, the MIDocs participating medical school must enter into an agreement with the state agency specifying the number of MIDocs residents to be supported, the total annual cost of such residencies, any post-residency expenditures to retain physicians in underserved areas of Michigan, and the amount of other sources of funding available for the program, if any. Sponsoring institutions may receive funding from other sources but Medicaid will act as a payer of last resort to only cover costs not reimbursed through other sources. The state agency will pay the MIDocs participating medical school an amount equal to the amount of otherwise unreimbursed costs.

The single state agency will approve four (4) agreements with MIDocs participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total $1.52 million in fiscal year 2019, $10.73 million in fiscal year 2020, $19.98 million in fiscal year 2021, $27.75 million in fiscal year 2022, $28.5 million in fiscal year 2023, and $22.8 million in fiscal year 2024.

In addition, the following requirements must be met:

- The MIDocs participating medical school must have submitted to the state agency its MIDocs program proposal for new or expanded residency program(s) to promote access in underserved areas of the state.
- The new or expanded program(s) must possess appropriate accreditation credentials.
- The new or expanded program(s) must meet the MIDocs curriculum standards, including those related to didactic education on patient centered medical homes, interprofessional education, behavioral and physical health integration, and continuous quality improvement.
- The MIDocs participating medical school must be the sponsoring institution of the residency program(s) or have an approved agreement with the sponsoring institution.
- The MIDocs participating medical school or the sponsoring institution (if not the medical school) must have agreements with all training sites for the MIDocs residents.
- If GME distributions exceed the expenses incurred by the MIDocs participating medical school, their affiliated sponsoring institution and/or the clinical training sites related to the MIDocs residencies, the size of the payment will be reduced to bring these elements into alignment.

SECTION 9 - COST REPORTING REQUIREMENTS

Each hospital, unless specifically exempt, is required to submit a MDHHS Facility Settlement Medicaid Cost Report to the MDHHS HCRD on or before the last day of the fifth month following the close of its cost reporting period. The HCRD grants extensions only when a hospital's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the hospital, whereas fires and floods would be considered beyond its control). If a hospital fails to submit a completed Medicaid Cost Report via the MDHHS Facility Settlement system on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the Medicaid Cost Report is not submitted within 30 calendar days from the date of the notice of delinquency, the hospital's payments are terminated until the Medicaid Cost Report is received and accepted by MDHHS in the Facility Settlement system. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report.

The cost report covers a 12-month cost reporting period unless the Medicare and Medicaid Programs have granted prior approval. Approval for filing a cost report for a period other than 12 months may be granted when a hospital changes the end date of its cost reporting period. In such case, the hospital is required to file a Medicaid Cost Report for the period between the end of the original cost reporting period and the beginning of the new cost reporting period.

Hospitals with subacute ventilator dependent care units must obtain MDHHS approval to file Medicaid Cost Reports treating the unit as a subprovider in accordance with the HIM-15 2336, 2336.1, 2336.2, and 2336.3. MDHHS approval must be requested in writing from the HCRD and must be obtained prior to the start of the first hospital fiscal year during which the exemption applies.

Each hospital's Medicaid Cost Report data must include an itemized list of all expenses recorded from the formal and permanent accounting records of the facility. The accrual method of accounting is mandated for all facilities not owned by government. Generally accepted accounting principles must be followed. All of the hospital's accounting and related records, including the general ledger, books of original entry, and statistical data, must be maintained for at least three years after receipt of final settlement (42 CFR §413.20 and Provider Reimbursement Manual §2304; 42 CFR §405.1885). These records must be made available for verification during onsite visits by state or federal audit staff. All Medicaid Cost Reports are retained by MDHHS for at least three years following the date of settlement.

The Medicaid Cost Report must be sent to MDHHS HCRD via the Facility Settlement system. The Medicaid Cost Report must include:

- The CMS 2552 Medicare standardized electronic cost report (ECR) filed in the manner required by MDHHS for MDHHS programs reporting.
- MDHHS specific filed Medicaid Cost Report.
- The hospital's audited Financial Statements.
- Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges.

The Medicaid Cost Report is accepted only if all of the following conditions are met:

- All submitted documents are in a usable format.

- MDHHS can generate a full CMS 2552 cost report from the electronic cost report file. MDHHS uses the KPMG/CompuMax system to generate viewable cost reports.
- Data is provided for all authorized MDHHS units and programs (Medical/Surgical, Rehabilitation, Outpatient, Psychiatric, Clinic, Title V, Title XIX and Healthy Michigan Plan).
- Data meet a set of reasonableness checks, or variances are explained. Hospital charges on cost reports must be supported with approved Medicaid claims data. The DSH audit survey (42 CFR 455.301 and 42 CFR 455.304) allows hospitals to complete a reconciliation between MMIS and internal hospital data to assure that all eligible claims are accounted for during the audit.
- Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges.
- Hospitals must maintain an active NPI and accurate specialty enrollment information as described in the General Information for Providers chapter of the Medicaid Provider Manual.

SECTION 10 – AUDITS

The audit and settlement process determines the amount of reimbursement to which an individual hospital is entitled. Cost settlements are made to assure payment of the MDHHS share of reimbursable cost. The audit and settlement process begins with the receipt of the hospital's annual cost report and ends with the electronic issuance of the Notice of Amount of Program Reimbursement that conveys the results of the audit.

10.1 DESK AUDIT

The audit process includes desk audit procedures and audit scope determinations for both MDHHS program(s) audit verification purposes and determination of allowable costs. All cost reports are examined to:

- Verify the completeness and arithmetic accuracy of all schedules in the report;
- Reconcile reported hospital program data with MDHHS approved data; and
- Identify the need for supporting documentation and arrange to receive same.

SECTION 11 – SETTLEMENTS

11.1 INITIAL UPPER PAYMENT LIMIT

In aggregate, MDHHS limits hospital reimbursement to the maximum allowable under the Federal upper payment limits (UPL) for services provided to Medicaid beneficiaries. MDHHS calculates inpatient and outpatient UPLs by benefit plan using CMS 2552 and Medicaid Cost Reports. The UPL calculation is completed at the time MDHHS accepts a hospital's Medicaid Cost Report and recovers amounts in excess of calculated limits.

11.2 HOSPITAL UNDERPAYMENTS AND OVERPAYMENTS

11.2.A. UNDERPAYMENTS TO A HOSPITAL

MDHHS pays a determined amount of an initial settlement due a hospital after notice has been furnished to the hospital. However, MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

11.2.B. OVERPAYMENTS TO A HOSPITAL

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and is recovered by MDHHS after notice has been furnished to the hospital.

11.3 FINAL SETTLEMENT(S)

Settlement is based upon processed non-zero dollar MDHHS liability claims for services rendered to MDHHS beneficiaries during the Medicaid Cost Report period and remitted prior to the paid claim report run date. MDHHS calculates the final settlement amount to be reimbursed no earlier than 27 months after the period covered by the Medicaid Cost Report. MDHHS may approve requests for final settlement calculations prior to 27 months in the event of hospital bankruptcy or closure. Upon completion, the final settlement results are transmitted to the hospital via the Facility Settlement system, the Medicare/Medicaid CMS 2552 report and/or the Medicaid Cost Report and will not be amended unless specific cost report changes are approved by MDHHS. Facilities can appeal or request changes to the final settlement up to 30 calendar days from the final settlement completion date noted in the Facility Settlement system.

The total amount paid for inpatient capital is eligible to be settled 27 months after the hospital's fiscal year ends. For testing against the Medicaid upper payment limits, inpatient payments are limited by allowable inpatient charges and outpatient payments are limited by allowable outpatient costs. Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), including capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments. Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs.

For the purpose of the hospital final settlement process only, hospitals that participate in the Medicaid FFS 340B program will have the option to have their 340B drug costs adjusted from actual acquisition cost to a hospital's normal and customary charge. Participation in the 340B final settlement adjustment

process is contingent on the provision of sufficient documentation to confirm the reasonableness of reported charges. This adjustment will not apply to drug reimbursement, and participating providers are required to continue to bill 340B actual acquisition cost and all applicable modifiers. This policy does not impact or require any additional action for providers that do not participate in the Medicaid FFS 340B program. This policy is effective for final settlements with fiscal year ends between October 1, 2015 and December 31, 2023, and does not apply to prior settlements or settlements reopened prior to this effective date. Hospitals that do not have December 31, 2023, fiscal year ends will have final settlements split based on claim date of service.

11.4 Responses to the Final Settlement

The Facility Settlement system contains a descriptive list of all program data adjustments made to a Medicaid Cost Report by the MDHHS HCRD audit staff. The Notice of Amount of Program Reimbursement is the notice of final determination and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration.

The process is initiated by the hospital after the receipt of the Facility Settlement system notification. The MDHHS HCRD concludes the process on the day the Notice of Amount of Program Reimbursement is electronically transmitted to the hospital.

The final settlement result must be accepted or rejected by the hospital within 30 calendar days of the Notice of Amount of Program Reimbursement being electronically transmitted to the hospital.

The hospital may take the following actions:

- **Hospital Accepts the Notice of Amount of Program Reimbursement**

  If the hospital accepts the findings contained in the final settlement, an appropriate officer of the hospital must electronically sign the final settlement within the Facility Settlement system. The MDHHS Notice of Amount of Program Reimbursement will be electronically transmitted to the hospital. No further administrative appeal rights will be available for the adjustments contained in the final settlement.

- **Hospital Does Not Respond to the Notice of Amount of Program Reimbursement**

  If the hospital does not respond within the 30 calendar day time period, MDHHS shall electronically transmit a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.

- **Hospital Rejects the Notice of Amount of Program Reimbursement**

  If the hospital rejects any or all of the findings contained in the final settlement within 30 calendar days of the transmit date of the Notice of Amount of Program Reimbursement, then an informal appeal can be requested. An informal appeal process involves the audit staff and the hospital working to resolve differences prior to a formal appeal. The hospital may request a formal appeal hearing through the administrative appeal process.

11.5 Reopening of Settlements

For all MDHHS final settlement reopenings, MDHHS has adopted and follows all applicable provisions of the Medicare Provider Reimbursement Manual (HIM-15), Part 1, Sections 2931 and 2932, as well as all applicable provisions of 42 CFR Section 405.1885 et. seq.

For all reopenings, there is a three-year statute of limitations that begins on the date of the original MDHHS Notice of Amount of Program Reimbursement. The three-year time period ends on the third anniversary of that date. A separate Facility Settlement system notification regarding settlement recalculation will be required for each provider and each cost year. If MDHHS electronically notifies a provider of its settlement recalculation before the expiration of the three-year period, the three-year requirement will be considered met. After this point, the reopened settlement will be completed in a timely fashion.

A Medicare settlement reopening will not affect the application of the three-year time limit on MDHHS settlement reopenings. Once the final settlement has been calculated and sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended without specific CMS 2552 changes being approved by MDHHS.

New laws, regulations, policy directives, or the interpretation of such issued subsequent to a settlement will not serve as basis to reopen a settlement. Additionally, the above cannot be introduced as part of a reopened settlement. The sole exception is when MDHHS is directed to do so by court order.

SECTION 12 - APPEALS

12.1 DATA CORRECTIONS

Once a hospital report (e.g., cost, indigent volume, and/or data) has been reviewed and provisionally accepted by MDHHS, the hospital is notified in writing of MDHHS acceptance of the report. The hospital then has 30 calendar days in which to notify MDHHS of any errors or corrections to the report/data. After the 30-day notification period, the report is deemed accepted by MDHHS and will be used to rebase or update the hospital's pricing components as appropriate.

Only those reports on file and accepted nine months prior to the beginning of a new rate period are used for rebasing.

12.2 PRICE APPEALS

MDHHS considers appeal requests received within 30 calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to MDHHS. Requests must clearly state the item(s) being appealed, the remedy being sought, and must include all necessary documentation to support the hospital's position. Appeal requests received after 30 calendar days are not accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:	Items not subject to appeal include:
▪ Interpretations and/or application of program: ➢ Policy ➢ Procedures ➢ Formulas ➢ Pertinent laws and regulations (e.g., Code of Federal Regulations, HIM-15, etc.) ▪ Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by MDHHS.	▪ Data previously submitted by the hospital and accepted by MDHHS. ▪ The establishment and use of DRGs. ▪ The Medicare Principles of Reimbursement (e.g., 42 CFR, HIM-15, etc.) as adopted by MDHHS and used to reimburse providers. ▪ The use of relative weights as part of the DRGs. ▪ Interim payment rates which are in compliance with state and/or federal regulations. ▪ Nonprogram related issues.

Appeal requests must be sent to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

12.3 APPEAL PROCESS

Upon receipt of an appeal request, a conference is scheduled and conducted by MDHHS staff from MOAHR. During this conference, the MDHHS staff and hospital representatives discuss the issues related to the appeal.

Failure to appear at a scheduled conference without good cause and reasonable advance written or telephone notification to the MDHHS staff person assigned to the appeal is considered an abandonment of the appeal.

After the conference, a final determination notice is sent to the hospital outlining the MDHHS position on the item(s) appealed.

A price appeal decision may include a correction to the data used to set rates. If so, the corrected data is used beginning with the rate period for which the appeal was filed. Data corrections and any resultant price component changes that are accepted through pre-hearing conference or prevail at hearing are made for the current base period only for the hospital filing the appeal. MDHHS may make changes to price components that affect all providers in subsequent rebasing periods.

Hospitals may elect to appeal an adverse action by requesting an administrative hearing as provided in MDHHS Provider Hearing Rules, R 400.3402 through R400.3404. Requests for hearing must be sent to MOAHR. Appeal requests must be made in writing and received within 30 calendar days of the notice of adverse action. If an appeal is not made in a timely manner, the notice of adverse action is final.

12.4 Administrative Hearings

Hearings conducted by MOAHR follow the MDHHS Provider Reviews and Hearings Rules found at R400.3406 through R400.3424.

SECTION 13 - ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM FOR HOSPITALS

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, authorized incentive payments through Medicare and Medicaid to eligible hospitals as they adopt, implement, and/or upgrade, or demonstrate meaningful use of certified Electronic Health Record (EHR) technology. The hospital incentive program is designed to support hospitals in a period of health information technology transition and instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care.

The purpose of EHRs and meaningful use is to:

- Improve quality, safety, efficiency, and reduction of health disparities;
- Engage patients and families in their health care;
- Improve care coordination;
- Improve public health; and
- Ensure adequate privacy and security protections for personal health information.

13.1 REGISTRATION AND INTERFACES WITH THE NATIONAL LEVEL REPOSITORY

All hospitals seeking an EHR incentive payment are required to register with the National Level Repository (NLR). The NLR is the federal database which verifies basic provider information prior to notifying State Medicaid programs of a provider's intent to participate in the Medicare and Medicaid EHR Incentive Program. To register with the NLR, all Eligible Hospitals (EHs) must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain, and Ownership System (PECOS). Registration requires an active user account in the National Plan and Provider Enumeration System (NPPES). Note that any revisions to information provided in the NLR must be modified at the NLR level.

MDHHS is notified upon successful registration with the NLR. EHs are directed to the Michigan Medicaid Community Health Automated Medicaid Processing System (CHAMPS) to begin the Michigan Medicaid EHR registration process. The EHR Incentive Program module was created within the CHAMPS system to collect and record EH data. All providers have up to 30 days from MDHHS receipt of the NLR file to submit completed registration information in the CHAMPS EHR module. Failure to do so in the allotted timeframe could require hospitals to re-register at the NLR level. Providers must be an enrolled Michigan Medicaid provider and have an active Payee-Tax Identification on record within SIGMA Vendor Self Service (VSS). EHs are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have adopted, implemented and/or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds.

Following EH data collection in the NLR and Medicaid EHR CHAMPS module, EH eligibility determinations are calculated.

Following a successful eligibility determination, EH payments are calculated. A final report is filed with the NLR following a processed EHR incentive payment.

13.2 Requirements for Participation

In order to participate in the Michigan Medicaid EHR Incentive Program, hospitals must be a Medicaid enrolled provider and have a completed Medicaid Quarterly Report, Medicaid Cost Report and CMS 2552 Cost Report on file with MDHHS that correlates with the specified timeframe from which data are pulled. In an effort to have the most complete and accurate information for program calculations, all revisions, amendments, and modifications to data sources used in eligibility and payment calculations must be complete prior to hospital registration in the EHR Incentive Program. Incomplete data sources or data that is under revision are not utilized; therefore, hospital eligibility determinations and payment calculations could be delayed as a result.

Hospitals must review and agree to the attestation requirements outlined in the Michigan Medicaid EHR CHAMPS module. EHs select their EHR status (e.g., Adopt, Implement, and/or Upgrade or Meaningful Use) and provide their EHR certification number. EHs attest that the information they are providing is true, accurate, and complete.

EHs may participate in both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals must choose only one state from which to register and receive a Medicaid EHR incentive payment.

13.3 Eligible Hospitals Defined

Per CMS, eligible hospitals are defined as follows:

- Acute care hospitals (includes critical access hospitals [CAH]) and cancer hospitals meeting the following requirements:
  - A health care facility where the average length of patient stay is 25 days or fewer,
  - CMS Certification Number (CCN) ending between 0001 and 0879 or 1300-1399, and
  - Meet a Medicaid patient volume threshold of at least 10%; **or**
- Children's hospitals (does not include children's wings of larger hospitals) which are separately certified children's hospitals with CCN ending between 3300 and 3399.

  Children's hospitals do not have to meet a minimum Medicaid patient volume threshold.

13.4 Eligibility Verification

To verify hospital eligibility, data reported on the CMS 2552, Medicaid Quarterly Report, and the MMF are utilized. Eligibility requirements are calculated annually upon registration in the Medicaid EHR Incentive Program. Hospitals should confirm that all necessary data elements are complete and reported for EHR incentive calculation purposes.

13.4.A. Average Length of Stay (LOS)

Average LOS is calculated by reviewing the current CMS 2552 Cost Report and Medicaid Cost Report on file with MDHHS. The following calculation is used:

Total Inpatient Days/Total Inpatient Discharges = Hospital Average LOS

13.4.B. Medicaid Eligible Patient Volume

A hospital's Medicaid eligible patient volume is calculated using the Medicaid Quarterly Report. Acute care hospitals must annually meet a 10% Medicaid eligible patient volume threshold to participate in the EHR Incentive Program. EH Medicaid eligible patient volumes are verified each year of a hospital's participation in the EHR Incentive Program. (Children's hospitals are exempt from the volume threshold requirement.) MDHHS will select the hospital quarter with the highest Medicaid eligible patient volume (90-day continuous period) from the applicable calendar year's Medicaid Quarterly Report to derive program eligibility. For purposes of measuring Medicaid eligible patient volume, an inpatient hospital day or hospital discharge with a Medicaid-enrolled patient, including those with no Medicaid payment liability, is considered an encounter. One of two calculation methods is utilized to determine Medicaid eligible patient volume. The quarter of the prior calendar year and calculation method that yields greater Medicaid eligible patient volume is utilized to determine hospital eligibility. Patient encounters include both Fee-for-Service (FFS) and Managed Care Organization (MCO) data.

One of the following calculations will be utilized to determine Medicaid Patient Volume:

$$\frac{\text{Total Medicaid Hospital Days}}{\text{Total Hospital Days}} \times 100 = \text{Medicaid Patient Volume}$$

OR

$$\frac{\text{Total Medicaid Hospital Discharges}}{\text{Total Hospital Discharges}} \times 100 = \text{Medicaid Patient Volume}$$

13.5 Incentive Payment Calculation

EHR Incentive Program payments are calculated in accordance with the formula outlined in the HITECH under Section 495.310. Payments are made over a total of three years and are paid 50% of the aggregate calculation in the first year, 40% in the second year, and 10% in the third year.

13.5.A. TIMING

EHs that adopt, implement, and/or upgrade a certified EHR system or are meaningful users can begin receiving incentive payments in any year from 2011 to 2016. The Medicaid EHR Incentive Program operates on a calendar year (CY) reporting period (January 1 through December 31). While the statute defines a payment year in terms of a CY, a hospital does not have to begin receiving incentive payments in CY 2011. However, the last year a hospital can first receive an initial Medicaid incentive program payment is CY 2016.

EHs are paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three-year period. Data utilized to calculate the aggregate EHR hospital incentive amount is derived from filed hospital cost reports (CMS 2552 and Medicaid Cost Report) from the hospital CY that ends during the CY prior to the hospital CY that serves as the first payment year.

All revisions, amendments, and modifications to data sources must be completed prior to a hospital's registration for the EHR Incentive Program. This includes revisions to the filed cost reports (CMS 2552 and Medicaid Cost Report) used to calculate the aggregate EHR incentive amount. Incomplete hospital data sources will result in delays in eligibility determinations and payment calculations.

13.5.B. PAYMENT FORMULA

The aggregate EHR incentive amount is a one-time calculation based upon the sum of a theoretical four-year calculation period where the amount of each year is the product of the following factors:

- the overall EHR amount; and
- the Medicaid Share.

The overall EHR amount is also based upon the sum over a theoretical four-year calculation period where the amount of each year is the product of two factors:

- an Initial Amount; and
- the Transition Factor applicable to each of the four years.

(All data used in the payment calculation is derived from the same 12 month cost report period, other than discharge data used to calculate the annual growth rate.)

Initial Amount and Theoretical Four-Year Calculation Period

The Initial Amount is the sum of a base amount and a discharge-related amount. The base amount is $2,000,000, and the discharge-related amount provides an additional $200 for estimated discharges between 1,150 and 23,000. No discharge-related amount is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge.

For the first calculation year, data on hospital discharges from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year is used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent theoretical calculation years, the number of discharges is based on the average annual growth rate for the hospital over the most recent three years of available data. The growth rate is based on a three-year average of total discharges, beginning with the initial calculation year and including data from the three prior years. The annual growth rate is applied to the base year's discharges to arrive at the three subsequent year discharge amounts. If an EH's average annual rate of growth is negative over the three-year period, the rate is applied as such.

Transition Factor

For each of the four years of the calculation, a different transition factor applies. The aggregate Medicaid EHR Incentive Payment is calculated once and is then distributed over three actual payment years. The transition factors listed below are used to calculate the aggregate EHR amount but do not indicate that hospital payments will be recalculated on a yearly basis.

Theoretical Calculation Period	Transition Factor
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

Medicaid Share

The Medicaid Share is the percentage of a hospital's inpatient, non-charity care days that are attributable to Medicaid inpatients.

The numerator of the Medicaid Share is the sum of:

- The estimated number of Medicaid inpatient bed days; and
- The estimated number of Medicaid managed care inpatient bed days.

The denominator of the Medicaid Share is the product of:

- The estimated total number of inpatient bed days for the eligible hospital during that period; and
- The estimated total number of the eligible hospital's charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital's charges during that period.

For the purposes of the EHR incentive payment calculation, charity care is calculated using data from the Medicaid Cost Report Indigent Volume worksheet as follows:

(Total Uncompensated Charges **–** Third Party Bad Debts **–** Uninsured Payments from Charges **–** Recoveries for Uninsured Bad Debt) **=** Charity Care

The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

Payment Calculation Summary

1. Calculate initial amount	$2 million base amount + ((discharge bonus)*200) = initial amount $200 per total discharge between 1,150 and 23,000
2. Calculate four theoretical years	Year 1: 100% of initial amount Year 2: 75% of initial amount (**+** or **–** any change in discharge level based on annual growth rate) Year 3: 50% of initial amount (**+** or **–** any change in discharge level based on annual growth rate) Year 4: 25% of initial amount (**+** or **–** any change in discharge level based on annual growth rate)
3. Sum four theoretical year calculations	Year 1 + Year 2 + Year 3 + Year 4 = Aggregate Hospital EHR Incentive Amount
4. Calculate Medicaid Share	Medicaid inpatient days / (total inpatient days * ((gross revenue – charity) / gross revenue))
5. Multiply Aggregate Hospital EHR Incentive Amount by Medicaid Share	Aggregate Hospital EHR Amount * Medicaid Share = Total Hospital EHR Incentive Amount
6. Paid over three payment years	Payment Year 1 = 50% of Total Hospital EHR Incentive Amount Payment Year 2 = 40% of Total Hospital EHR Incentive Amount Payment Year 3 = 10% of Total Hospital EHR Incentive Amount

13.6 Payment Notification and Gross Adjustments

EH Medicaid Incentive payments are made annually via gross adjustment. EHs cannot receive more than one incentive payment in each State CY.

Following the verification of hospital eligibility, an incentive payment is calculated and the EH is notified of the final amount. EHs have up to 30 days from receiving their payment notice to dispute payment calculations. If no communication is received or the EH agrees with the payment notice, the incentive payment is processed via gross adjustment in the CHAMPS system.

13.7 Adopt, Implement, and/or Upgrade or Meaningful Use

To receive a first year's incentive payment, EHs must attest to adopting, implementing, and/or upgrading (AIU) a certified EHR system. EHs are required to provide the certification number of their EHR system within the EHR CHAMPS module during registration as part of AIU attestation. Eligible Medicaid hospitals can receive their first year's payment for AIU attestation and not meaningful use, but must meet the meaningful use requirement in all subsequent participation years.

If an EH is eligible for both Medicare and Medicaid EHR Incentive Programs and has achieved meaningful use standards under Medicare, they are recognized as a meaningful user for Medicaid purposes.

In order to continue to receive incentive payments after the first payment year, providers must achieve and maintain a set of meaningful use measures as defined by CMS. Meaningful use employs a three-stage approach, with each stage building on the preceding stage:

- Stage 1 – Data capture and sharing
- Stage 2 – Expand on Stage 1 criteria to encourage the use of health information technology for continuous quality improvement
- Stage 3 – Expand on Stage 2 with a focus on promoting outcomes in quality, safety, and efficiency

To demonstrate Stage 1 of meaningful use, an EH must comply with a set of "core" requirements and a selection of "menu" requirements. MDHHS has adopted the same requirements outlined by CMS without modification.

SECTION 14 – SHORT-STAY HOSPITAL REIMBURSEMENT

The State utilizes a Short Hospital Stay (SHS) rate of reimbursement for certain outpatient and inpatient hospital stays. The SHS encompasses funding for both operating and capital costs. The SHS rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. The SHS rate is published on the MDHHS website. (Refer to the Directory Appendix for website information.)

The SHS rate of reimbursement does not modify billing requirements for hospitals. If the patient meets criteria for an inpatient admission, the claim must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the claim must be submitted as an outpatient claim. In either case, if the criteria for the SHS rate are met, the hospital will receive the same reimbursement for services rendered. The SHS rate only applies to discharges from a facility, and does not apply to transfers, leaving against medical advice (AMA), or other discharge statuses.

The SHS logic will apply to both emergent and elective claims. For purposes of this reimbursement structure, SHSs will be defined using the following criteria.

14.1 DIAGNOSES

In order to qualify for a SHS rate, a claim must include one of the primary diagnosis codes listed on the SHS rate diagnosis code table. The SHS rate diagnosis code table is maintained on the MDHHS website. (Refer to MDHHS Institutional Billing Resource in the Directory Appendix for website information.) The list of eligible codes will be evaluated annually and updated as necessary.

14.2 OUTPATIENT HOSPITAL CLAIMS QUALIFICATION

An outpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the outpatient claim is listed on the primary diagnosis codes list referenced above.
- The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim.
- The claim does not include cardiac catheterization lab revenue code 481.
- The claim includes observation revenue code 762.

14.3 INPATIENT HOSPITAL CLAIMS QUALIFICATION

An inpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the inpatient claim is listed on the primary diagnosis codes list referenced above.
- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
- The claim has a date of discharge equal to or one day greater than the date of admission.
- The claim does not include cardiac catheterization lab revenue code 481.

14.4 Exclusions

The SHS logic will not apply to inpatient or outpatient claims with the following conditions:

- Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible.
- Hospital discharges with discharge status codes other than 1, 6, 9, 21, 30, 50, or 51.
- Claims for patients who leave the hospital AMA.
- Claims for deceased patients.
- Claims that include primary diagnoses that are not on the diagnosis list referenced above, including claims for births and deliveries, for example.

14.5 Short Hospital Stay Rate and Methodology

A single SHS rate will be developed for certain outpatient and inpatient hospital stays. This rate will encompass funding for both operating and capital costs, will be identical for inpatient and outpatient services, and will encompass all services billed on the claim.

The rate will be established using Medicaid hospital Fee-for-Service paid claims and managed care encounters that meet the SHS criteria. To calculate the rate, the following process will be employed:

- Aggregate Fee-for-Service operating payments on qualifying claims with dates of service during the second previous fiscal year will be identified.
- Aggregate Fee-for-Service capital payments will be calculated by multiplying the Fee-for-Service inpatient claims count for qualifying claims with dates of service during the second previous fiscal year by the current year statewide capital rate.
- Aggregate managed care operating and capital payments on qualifying encounters with dates of service during the second previous fiscal year will be identified.
- Fee-for-Service and managed care operating and capital payments will be aggregated and divided by the number of claims and encounters that meet the SHS criteria. The resulting quotient will be the SHS rate.

MDHHS will monitor the diagnosis code sets and reimbursement to ensure budget neutrality is maintained or to maintain consistency with future reimbursement changes.

INDEPENDENT DIAGNOSTIC TESTING FACILITIES AND PORTABLE X-RAY SUPPLIERS

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SECTION 1 - INTRODUCTION

1.1 GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) enrolls and reimburses Independent Diagnostic Testing Facilities (IDTF) and Portable X-ray Suppliers (PXRS) for Medicaid covered diagnostic services. An IDTF or PXRS may provide services in a mobile facility or portable unit and is independent of a physician's office or hospital. Providers and equipment must comply with all federal, state and local regulations applicable to the type of service(s) provided.

MDHHS aligns with Medicare's IDTF and PXRS policies whenever possible. IDTF and PXRS entities must be enrolled with Medicare before requesting to enroll with Michigan Medicaid. (For information on the MDHHS Provider Enrollment process, refer to the General Information for Providers Chapter in this manual).

SECTION 2 - GENERAL INFORMATION FOR IDTF AND PXRS BILLING AND REIMBURSEMENT

Claims for enrolled providers are submitted in the ASC X12N 837 5010 professional format to the MDHHS Community Health Automated Medicaid Processing System (CHAMPS).

- Michigan Medicaid reimbursement for IDTF and PXRS services is based upon the limits and rates associated with MDHHS physician professional services.
- Procedure codes and fee screens for the IDTF or PXRS are available on the MDHHS website and in the Medicaid Code and Rate Reference tool in CHAMPS. (Refer to the Directory Appendix for website information.)
- To bill transportation and set up codes for portable x-rays, an IDTF must qualify and be enrolled as a PXRS.

A referral or an order for a diagnostic test or x-ray is required from the provider treating the patient. Providers arranging or rendering services upon the order of another provider must maintain that order for a period of seven years.

When an enrolled IDTF or PXRS provides the professional component (PC) interpretation from a distant site, the Place of Service (POS) codes assigned by the physician or other provider will be the setting in which the patient received the technical component (TC) of the service.

Michigan policies regarding National Provider Identifier (NPI) Type, Global or Component Billing, and Referring/Ordering and Supervising Providers are available in this manual. Refer to the General Information for Providers, Billing & Reimbursement for Professionals, and Practitioner chapters for complete descriptions on required claim information.

SECTION 3 - INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTF)

An IDTF is approved to provide specific diagnostic tests when performed by licensed, certified personnel (42 CFR 410.33). The IDTF must provide the appropriate amount of physician general supervision based on the number of enrolled locations.

The IDTF may have either a fixed or mobile location and different practice sites. Each practice location and/or mobile unit must be separately enrolled and meet all applicable requirements for the type of diagnostic test performed. A mobile IDTF can provide portable x-ray services if the provider is enrolled with Medicare for this service. To bill transportation and set up codes, the IDTF must also be a qualified and enrolled PXRS.

An IDTF does not provide therapeutic procedures. Test results from an enrolled IDTF are used by the referring provider in the medical management of the beneficiary.

SECTION 4 – PORTABLE X-RAY SUPPLIERS (PXRS)

In compliance with 42 CFR 410.32 (c) (i-ii), PXRS are limited to performing Medicaid covered x-rays of the extremities, pelvis, spine, skull, chest and abdomen. There must be one or more physicians who are responsible for the general supervision of the PXRS as described in 42 CFR 486.102.

An order from the provider treating the patient is required. The order must specify both the reason for the x-ray and the need for portable services.

PXRS claims may include up to four components:

- transportation when x-ray equipment is taken to the location where services are performed,
- set-up of the equipment,
- administration of the x-ray (technical component), and
- interpretation of the x-ray (the professional component).

Appropriate HCPCS and Level II HCPCS modifiers are required. If only one patient is served, report the appropriate HCPCS code. When more than one patient is served during a single trip to the same location, report the appropriate HCPCS code with the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) relative to the number of patients served, irrespective of their insurance. The modifier determines the number of beneficiaries served at a location, and total payment for services is adjusted by the number of patients.

Portable x-rays furnished in a place of residence used as the patient's home, including a nursing facility, require the corresponding POS code.

For dual-eligible beneficiaries during a Medicare Part A-covered skilled nursing facility stay, transportation and set-up costs will follow Medicare-consolidated billing policy and are not separately billable to Medicare Part B or to Medicaid. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken.

LABORATORY

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SECTION 1 - GENERAL INFORMATION

This chapter applies to laboratory services performed in practitioner offices, hospital laboratories, and independent clinical laboratories.

Medicaid covers diagnostic laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury. Testing performed in a profile, panel, or battery is covered only when all the included tests are reasonable and necessary for the beneficiary.

Covered laboratory and pathology services must be:

- Recommended and ordered by the beneficiary's treating physician or other licensed practitioner working within their scope of practice as determined under State law.
- Provided in accordance with evidence based generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site, and duration for the beneficiary's symptoms, diagnosis, illness, or injury.
- Used in the clinical management of the beneficiary's specific medical condition.
- Provided in accordance with all applicable Medicaid clinical criteria, requirements, policies, and/or provisions of coverage.
- Not primarily for the convenience of the beneficiary or provider.
- Performed in a laboratory appropriately certified by the Clinical Laboratory Improvement Amendments (CLIA).

The beneficiary's medical record must include sufficient documentation to support the need for the laboratory service.

Medicaid covers a limited number of screening laboratory services including, but not limited to, those specified for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, recommended as Grade A or B by the United States Preventive Services Taskforce, or identified in Medicaid policy. All other screening laboratory tests not reasonable or necessary for the diagnosis or management of the beneficiary's specific condition are not covered. This includes laboratory screening tests performed for investigational purposes only or as part of a clinical evaluation when the need for the test is not clinically indicated.

1.1 LABORATORY TYPES

1.1.A. PRACTITIONER'S OFFICE LABORATORY

Medicaid covers laboratory services provided in a physician's, physician assistant's (PA), nurse practitioner's (NP), clinical nurse specialist's (CNS), certified nurse midwife's (CNM), podiatrist's, or dentist's office laboratory when they are appropriate to be performed in the office. Practitioner's Office Laboratory (POL) reimbursement is limited to services listed on the applicable provider's fee schedule. Coverage includes procedures contained in the CLIA Physician Performed Microscopy list for appropriately

certified physicians. For the purposes of Medicaid, a POL meets the following parameters:

- A physician, PA, NP, CNS, CNM, podiatrist, dentist, or group of practitioners maintains the laboratory.
- The laboratory performs testing only on specimens generated by the practitioners of the practice. The laboratory does not accept specimens from other physicians, clinics, or laboratories outside of the practice.
- Laboratory services are billed using the practitioner's or group practice's National Provider Identifier (NPI) number.
- The laboratory holds a CLIA certificate of registration, compliance (COC), accreditation (COA) waiver (COW) or a certificate of Physician Performed Microscopy Procedures (PPMP) from the Centers for Medicare & Medicaid Services (CMS).

A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office (i.e., skin lesions, pap smears, etc.) for analysis.

1.1.A.1. Provider-Based Outpatient Hospital Clinics

Medicaid covers laboratory services provided in a provider-based outpatient hospital clinic when they are appropriate to be performed in a clinic setting. Outpatient provider-based hospital clinics are not considered POLs by Medicaid and must meet the following parameters:

- Owned and operated by a hospital.
- May be located on the same campus as the main hospital or located off-campus.
- Holds a CLIA certificate of registration, COC, COA, COW, or PPMP from CMS separate from the hospital if located off campus.
- Beneficiaries are treated as hospital outpatients for billing purposes.

1.1.A.2. Other Clinics

Medicaid covers medically necessary laboratory services provided in a variety of clinics including, but not limited to, family planning clinics, urgent care centers (UCCs), walk-in health clinics, school-based clinics, rural health clinics (RHC), federally qualified health centers (FQHC), and Indian health centers (i.e., tribal FQHCs and tribal health centers [THC]) when they are appropriate to be performed in these settings. These clinics are not considered POLs by Medicaid and covered laboratory services are limited to those appropriate for the clinic type. Providers should refer to the Family Planning Clinics, Urgent Care Centers, School Services Program, Tribal Health Centers, Rural Health Clinics, and Federally Qualified Health Centers chapters in this manual and Medicaid fee schedules for additional information related to these clinics.

1.1.B. Independent Clinical Laboratory

Medicaid covers laboratory services performed by an independent clinical laboratory. Independent laboratories are limited to providing only the laboratory services listed on the Medicaid Laboratory Fee Schedule. For the purposes of Medicaid, an independent clinical laboratory meets the following parameters:

- A freestanding clinical laboratory that is independent of a physician office, hospital, or hospital-based facility.
- May be owned by a physician, group practice, a pharmacy, or a non-physician.
- Laboratory services are billed using the independent clinical laboratory's NPI number.
- Holds a CLIA certificate of registration, COC, COA, or COW from CMS.

1.1.C. Hospital Outreach Laboratory

Medicaid covers laboratory services performed by a clinical laboratory located in or as part of a hospital. Laboratory services performed (either directly or under arrangement) for non-hospital patients (i.e., those who are neither a registered outpatient nor inpatient hospital patient) are considered performed by a hospital outreach laboratory.

For the purposes of Medicaid, a hospital outreach laboratory meets the following parameters:

- Furnishes laboratory tests to patients other than inpatients or registered outpatients of the hospital.
- Holds a CLIA certificate of registration, COC, or COA from CMS.
- Laboratory services are billed using either the hospital's NPI number or the hospital clinical laboratory's NPI number.
- Bills for services using Form CMS-1450 14x TOB.

1.2 Ordering Practitioner

Laboratory services provided to Medicaid beneficiaries can be ordered by the following Medicaid enrolled practitioners:

- Physicians (MD or DO)
- Physician assistant (PA)
- Advanced practice registered nurse (APRN) [including certified nurse practitioners (NP), certified clinical nurse specialists (CNS) and certified nurse midwives (CNM)]
- Certified Registered Nurse Anesthetists (CRNA)
- Podiatrist (DPM)
- Dentist (DDS or DMD)

Providers should only order laboratory services that fall within the practitioner's scope of practice. To be eligible for Medicaid reimbursement, claims for laboratory services must indicate the Medicaid enrolled, allowable ordering provider.

Medicaid does not cover any laboratory tests ordered by a chiropractor.

The ordering practitioner must document the medical necessity of laboratory tests in the beneficiary's medical record, regardless of where the test(s) is performed. The ordering practitioner is held responsible if they order excessive or unnecessary laboratory tests, regardless of who actually renders the laboratory services. The ordering practitioner is also held responsible for the medical necessity of every laboratory test that is ordered as part of a custom- or laboratory-designed panel. The ordering practitioner may be subject to corrective action related to these services, including recoupment of funds. The laboratory also may be subject to corrective action, including the recoupment of funds, if it submits a claim for laboratory services not specifically ordered by a practitioner.

These ordering requirements apply to all Medicaid beneficiaries. Claims for beneficiaries with Medicare or private insurance coverage will not be exempt from this requirement. (Refer to the specific Billing & Reimbursement chapters for additional information.)

Laboratory services performed by a laboratory or its employees may not be billed to the ordering practitioner.

1.3 Order Requirement

A signed order, a signed requisition, or a signed medical record supporting the provider's intent to order tests satisfies the order requirement for laboratory tests.

1.4 Standing Orders

Medically necessary laboratory services ordered and performed due to standing orders are eligible for reimbursement when they are based on clinical treatment protocols applicable to the specific beneficiary. Standing orders for routine screening tests are not covered unless the medical necessity is documented in the beneficiary's medical record. Ordering providers must maintain documentation of the standing order, medical necessity, duration, and frequency of the testing in the beneficiary's medical record.

1.5 Specimen Source

A tested laboratory specimen may be from any source unless the source is specified in the procedure code description.

1.6 Out of State/Beyond Borderland Laboratories

Medicaid reimburses enrolled out of state laboratories who are beyond the borderland area only if the service meets the criteria outlined in Medicaid policy. Laboratories should refer to the Out of State/Beyond Borderland Providers subsection located within the General Information for Providers chapter of this manual for more information. Non-emergent lab services performed by an out of state/beyond borderland laboratory must be prior authorized unless Medicare and/or private insurance has paid a portion of the service and the laboratory is billing Medicaid only for the coinsurance and/or deductible amounts.

Managed Care Plans follow their own prior authorization criteria for out of network/out of state services. Laboratories participating in a Medicaid Health Plan (MHP) should contact the plan for prior authorization information.

1.7 Repeat Tests

Medicaid does not cover tests or services that are duplicated due to laboratory error.

SECTION 2 - BILLING INFORMATION

Refer to the Billing & Reimbursement chapters of this manual for additional information about billing.

2.1 DATE OF SERVICE

When billing Medicaid for services rendered, the date of service (DOS) indicated on the claim must be the date the specimen is collected. Laboratory tests performed on a stored specimen must use the date the specimen was obtained from storage as the specimen collection date.

2.2 MEDICAL NECESSITY

The beneficiary's medical record and claims (with applicable attachments when required) must contain documentation of the medical necessity of the laboratory service including, but not limited to, descriptions of the beneficiary's symptoms and other findings that led the practitioner to order the laboratory test(s). An explanation of the laboratory testing method or the results of the diagnostic tests, whether normal or abnormal, is not documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

2.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATION

All providers must have a Clinical Laboratory Improvement Amendments (CLIA) certification to perform laboratory testing on specimens. CLIA certification includes a certificate of waiver, certificate for provider-performed microscopy procedures, certificate of registration, certificate of compliance (COC), or a certificate of accreditation (COA). A CLIA certification is needed for each location where laboratory testing is performed unless one of the following exceptions applies:

- The laboratory is not at a fixed location.
- The laboratory is a not-for-profit or Federal, State, or local government laboratory engaged in limited public health testing.
- The laboratory is located within the same physical location or street address as a hospital. The lab must be in a contiguous building on the same campus as the hospital and must be under common direction.

To be eligible for Medicaid reimbursement, a clinical laboratory must be certified to perform the specialties or subspecialties of tests billed to Medicaid as of the date the tests are performed. A laboratory's CLIA number must be present on the claim and laboratory providers are limited to billing the lab services that they are CLIA certified to perform.

Procedure codes subject to CLIA certification change each year. Medicaid aligns with CMS' identification of laboratory services subject to CLIA waived and non-waived certification. When performing tests that use waived methodologies, laboratories must enter the QW modifier with the appropriate Current Procedural Terminology (CPT) code to denote the waived test when billing Medicaid for services rendered.

Questions regarding CLIA certification should be addressed to the state licensing agency. (Refer to the Directory Appendix for contact information.)

2.4 Procedure Codes

Laboratories should refer to the current edition of the CPT or Healthcare Common Procedure Coding System (HCPCS) manuals published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. The laboratory is also subject to any pathology and laboratory guidelines listed in the CPT/HCPCS manual that provide definitions and/or instructions for specific tests.

If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) CPT/HCPCS procedure code. All laboratory NOC codes require prior authorization (PA).

For specifics regarding the CPT and HCPCS codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter or the Medicaid Code and Rate Reference tool on the MDHHS website for more information. (Refer to the Directory Appendix for website information.)

2.5 Component Billing

Most pathology procedures are billed together as a complete or global service, and a single charge is made for both professional and technical components. However, some pathology procedures are composed of professional and technical components that are billed separately by the laboratory facility and the practitioner. In these instances, the procedure code requires the use of a modifier to accurately identify the service component provided. Providers should not bill for component services when the entire procedure is performed.

Payment for the technical component to the laboratory includes personnel, materials, space, equipment, report of test results, and other items.

The professional component represents the professional services of a pathologist/hematologist. Medicaid covered professional components are limited to certain services as noted on the Practitioner and Medical Clinic Fee Schedule located on the MDHHS website. (Refer to the Directory Appendix for website information.) Payment for this component includes:

- Examination of the beneficiary, when indicated.
- Performance and supervision of the procedure.
- Reading, interpretation, and written report of the findings.
- Consultation with the ordering physician.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter for additional information regarding coverage parameters.

When the laboratory performs services for hospital inpatients, only the pathologist/hematologist can bill the professional component (the pathologist's services) directly to Medicaid. The technical component is included in the reimbursement to the hospital for the inpatient services.

2.6 Other Insurance

If the beneficiary has another insurance plan (e.g., Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s) including, but not limited to, PA and standards of coverage. (Refer to the Coordination of Benefits chapter for more information.)

Medicaid reimburses laboratories for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims even if Medicaid does not normally cover the service.

2.7 Billing for Services Performed by Reference Laboratories Under Arrangement with Enrolled Hospital Laboratories

Following Medicare guidelines and applicable state and federal laws in situations where an enrolled hospital laboratory must refer a specimen to another laboratory for testing, the hospital laboratory will be allowed to bill Medicaid for the arranged services provided by the reference laboratory under the following conditions:

- The reference laboratory holds the required CLIA certification and state licensure, if required, to perform the test;
- The enrolled hospital laboratory and the reference laboratory have a contractual agreement (as defined as "arrangement" in section 1861(w)(1) of the Social Security Act) to provide such services, with the referring hospital laboratory responsible for reimbursing the reference laboratory for the services; and
- If the service requires PA, the enrolled hospital laboratory must request and receive PA approval for the service to be performed by the reference laboratory. The PA number must be included on the claim.

The definitions of reference laboratory and referring laboratory may be found in the Glossary Appendix.

2.8 Billing for Laboratory Services Performed in a Hospital Clinic

Hospital owned or affiliated practices must bill for laboratory services performed in the office or clinic using the institutional claim format. Refer to the Hospital chapter for complete billing and reimbursement information.

2.9 Test Results

Reimbursement is made for tests performed using a method that yields quantitative results unless the nomenclature specifies a different method.

The mathematical calculation of two or more results to produce an index or ratio or any other result may not be billed as a separate independent test.

SECTION 3 - REIMBURSEMENT

Unless otherwise specified within Medicaid policy, Medicaid's reimbursement for laboratory services includes:

- collection, handling, and conveyance of the specimen(s);
- all supplies, reagents, equipment, and instrumentation used in the test's processing; and
- lab test results and analysis.

3.1 PRACTITIONER'S OFFICE OR INDEPENDENT CLINICAL LABORATORY

Reimbursement rates for laboratory services provided by a practitioner's office or independent clinical laboratory are established by MDHHS as a fee screen for each procedure. Medicaid uses the Medicare Clinical Laboratory Fee Schedule (MCLFS) prevailing fees as a guideline or reference in determining the maximum fee screens for individual laboratory procedures. Services are reimbursed at a maximum rate of 90% of the MCLFS. Minimally, the Medicaid Clinical Laboratory fee schedule is updated annually following the January release of the MCLFS.

A pathologist or hematologist, when billing separately, will be reimbursed for the professional component of pathology services. The professional component must be billed with the appropriate modifier and will be paid according to the rates established by the MDHHS Practitioner fee schedule.

3.2 OUTPATIENT HOSPITAL

Laboratory services provided by outpatient hospitals are reimbursed through the Medicaid Outpatient Prospective Payment System (OPPS). Laboratory tests provided in conjunction with other services are generally packaged as ancillary services and do not receive separate reimbursement unless otherwise indicated by the procedure code's OPPS payment status indicator and/or determined under OPPS claim processing rules. If the beneficiary is not considered a hospital patient, laboratory services provided by the hospital outreach laboratory are eligible for separate Medicaid reimbursement.

Generally, Medicaid follows Medicare's OPPS laboratory coverage and reimbursement policies whenever possible and appropriate. In instances where there are program differences, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified laboratory services will appear on the MDHHS OPPS Wraparound Code List and reimbursement rates will appear on the Carrier Priced Laboratory Codes List. Both lists are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined not to be medically necessary.

3.3 END STAGE RENAL DISEASE (ESRD) FACILITY

Reimbursement for routine laboratory services related to maintenance hemodialysis, peritoneal dialysis, and continuous cycling peritoneal dialysis (CCPD) dialysis are included in Medicaid's dialysis composite rate and may not be billed separately unless it is medically necessary to perform the services in excess of the frequencies indicated by Medicaid policy. This includes routine laboratory tests performed by either a

dialysis facility or by an outside laboratory. Providers should refer to the Dialysis (Hemodialysis and Peritoneal Dialysis) subsection of the Hospital chapter for laboratory tests included in the composite rate.

Laboratory services included in the composite rate should be billed to the dialysis facility when performed by an outside laboratory. The dialysis facility and the outside laboratory must coordinate billing to ensure duplicate payments do not occur. A freestanding dialysis center that performs its own laboratory tests and needs to bill for services outside of those included in the composite rate must enroll with Medicaid as an independent laboratory. Freestanding dialysis centers enrolled as independent laboratories are subject to the Out of State/Beyond Borderland Provider Medicaid policy. Providers should refer to the Out of State/Beyond Borderland Providers subsection located within the General Information for Providers chapter of this manual for more information.

SECTION 4 - SPECIAL COVERAGE

4.1 CHILDREN'S SPECIAL HEALTH CARE SERVICES COVERAGE

For beneficiaries with Children's Special Health Care Services (CSHCS) coverage only, CSHCS covers laboratory services related to the beneficiary's qualifying diagnosis and related conditions. Services should be ordered by the beneficiary's authorized CSHCS specialty provider and performed by a CSHCS approved laboratory to be eligible for reimbursement.

4.2 ANATOMIC PATHOLOGY

Cryopreservation (frozen cell storage and thawing) is a covered service for bone marrow transplants only.

4.3 ARSENIC TESTING

Arsenic testing is not covered when performed on hair and nail specimens.

4.4 CREATININE BLOOD TESTS

Serum creatinine laboratory tests are Medicaid covered. Tests should calculate and report the estimated Glomerular Filtration Rate (eGFR) for beneficiaries. The eGFR may be calculated based on a formula that combines the creatinine level with the beneficiary's age, gender, and other factors.

4.5 EVOCATIVE/SUPPRESSION TESTING

Medicaid does not cover these panel codes. Providers should report the individual test codes on claims.

4.6 DRUG SCREENING/MONITORING

Drug monitoring is an important tool for a variety of reasons including, but not limited to, beneficiary compliance/adherence to a prescribed regimen, determination of substances prior to initiating pharmacologic treatment, and substance misuse or abuse. Medicaid covers presumptive and/or definitive drug testing when medically necessary. The beneficiary's medical record must include the testing frequency, rationale for the drugs/drug classes ordered, rationale for the type(s) of testing ordered (presumptive, definitive, or both), and the results. Laboratories performing validity testing on specimens utilized for drug testing should not separately bill for the validity testing.

4.7 NEWBORN LABORATORY SCREENING

Newborn laboratory screening (via heel stick) includes testing for rare genetic, metabolic, blood, or other disorders recommended by the Advisory Committee on Heritable Disorders in Newborns and Children and by Michigan's Newborn Screening Quality Assurance Advisory Committee. Blood samples should be sent by the birthing hospital, center, or other healthcare facility to the MDHHS Bureau of Laboratories Newborn Screening Section for processing. (Refer to the Directory Appendix for additional information.) If the birth occurs outside of these entities, then it is the responsibility of the attending provider to collect and send the sample to the MDHHS laboratory. In the event of an abnormal test result, the results shall be reported by the MDHHS laboratory to the newborn's physician or healthcare provider, parent or legal

guardian, and the appropriate Newborn Screening (NBS) Program coordinating center or specialty referral center.

Newborn screening reimbursement is included in Medicaid's payment to the birthing hospital, birthing center, or other healthcare facility through the facility's Diagnosis Related Group (DRG) rate and is not separately reimbursable.

If a NBS disorder is suspected, follow-up diagnostic laboratory testing is a Medicaid covered benefit.

4.8 Organ or Disease Orientated Panels

Medicaid covers select AMA-approved organ-or disease-orientated panels. All tests within the panel must be medically necessary. When a complete panel is ordered and all the tests within the panel are performed on the same date of service, the laboratory must report a panel code. When some, but not all, tests identified in a panel are performed, the laboratory should report the services as individual tests. If a group of tests overlaps two or more panels, the laboratory must report the panel that incorporates the greater number of tests to fulfil the code definition and report the remaining tests as individual tests.

4.9 Pap Smear

Pap smear screening is a covered service when provided in accordance with Medicaid's preventive services policy as outlined in the Preventive Services subsection of the Practitioner chapter. More frequent pap smears may be covered when medically necessary. If a suspect smear requires additional interpretation by a pathologist, this service is also covered. Coverage for obtaining the cervical smear is included as a part of the pelvic examination and is not eligible for separate reimbursement.

4.10 Pathology Clinical Consultation

Pathology clinical consultations are covered when billed by a hematologist/pathologist for the review of abnormal laboratory test results if:

- The abnormality relates to the beneficiary's medical condition and corresponding medical care.
- The referring provider orders the review and records the order in the beneficiary's medical record.
- Additional medical interpretative judgement is required.
- A detailed report is sent to the referring provider.

Consultations cannot be billed for routine quality control review. (Refer to the current CPT manual for the guidelines for the provision of this service.)

4.11 Pregnancy Related Laboratory Services

Medicaid covers routine pregnancy testing (serum or urine human chorionic gonadotropin [hCG] qualitative method) and medically necessary prenatal or pregnancy related laboratory services required to support the health of the fetus or pregnant beneficiary.

4.12 Prostate Specific Antigen (PSA) Screening

Medicaid covers prostate specific antigen (PSA) laboratory tests when used in the screening for prostate cancer and performed in accordance with current, generally accepted professional standards of medical practice or determined medically necessary for the diagnosis or management of the beneficiary by the ordering/treating provider.

4.13 Specimen Collection [Changes Made 4/1/2025]

Specimen collection is the process of obtaining tissue, blood, urine, stool, or other bodily fluids for laboratory analysis. Specimen collection is considered to be an integral part of the laboratory testing procedure and is included in the reimbursement for the processing of the specimen. A separate specimen collection fee is allowed in special circumstances where the drawing, packaging, and mailing of a blood specimen are the only services provided. These situations are rare and include:

- A beneficiary is referred to a laboratory for the sole purpose of drawing, packaging, and mailing a blood sample to MDHHS for analysis (e.g., blood lead or human immunodeficiency virus (HIV) viral load). MDHHS provides specimen containers and mailing kits for the analysis. Requests for supplies and the samples for analysis should be sent to the MDHHS Bureau of Laboratories. (Refer to the Directory Appendix for contact information.)
- A beneficiary requires blood laboratory tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that is performing the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood-handling fee may be billed by the practitioner. The blood-handling fee is not a benefit when any other service is reimbursable on the same date of service.
- Specimens obtained by the Local Health Department (LHD) for blood lead analysis sent to the State Laboratory or outside clinical laboratory that is CLIA-certified to perform blood lead analysis. Refer to the Local Health Department chapter for additional information. **(text added 4/1/2025)**

Procedure code 36415 (routine venipuncture for collection of specimen[s]) must be used when billing Medicaid for the drawing, packaging, and mailing of the blood sample. LHDs may report either capillary or venipuncture for blood lead draws. **(text added 4/1/2025)** Only one collection fee for each beneficiary encounter, regardless of the number of specimens drawn, will be allowed. Blood specimen collection may only be billed when the laboratory is not owned, operated, or financially associated with the provider site in which the specimen was collected.

4.14 Urinalysis

The analysis of urine for the diagnosis and monitoring of illness and disease is covered by Medicaid.

If a single urine specimen is analyzed for the same chemical, element, compound, or substance by more than one method (i.e., automated, non-automated, qualitative, semi-qualitative, non-culture bacteriuria screen), only one method may be reported.

4.15 Blood Count

A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes a red blood cell (RBC) count, WBC count; hemoglobin (Hgb); hematocrit (Hct); mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), mean corpuscular hemoglobin concentration (MCHC), red cell distribution width (RDW), WBC differential, and a platelet count (PLT). If automated instrumentation yields additional test results, the additional tests are not separately reimbursable unless medically necessary and specifically ordered by a practitioner.

4.16 Microbiology Studies

Definitive culture procedure codes may not be billed in combination with other microbiology codes that duplicate the identification of a microbe.

Coverage and reimbursement for gram fluorescent/acid fast is included in the reimbursement for microbiology when performed on the same date of service (DOS) for the same beneficiary.

SECTION 5 – GENETIC AND MOLECULAR TESTING

5.1 GENERAL INFORMATION

A genetic test or molecular test as defined in §17001 of Public Act 368 of 1978 means the analysis of human deoxyribonucleic acid (DNA), ribonucleic acid (RNA), chromosomes, and those proteins and metabolites used to detect inheritable or somatic disease related genotypes or karyotypes. These specialized diagnostic laboratory tests may identify increased risks of health problems, help choose treatments, or assess patient responses to treatments.

Medicaid covers genetic and molecular tests when clinically indicated by one or more of the following:

- The test is necessary to confirm a suspected genetic disease/condition when a definitive diagnosis remains uncertain, and the results will directly impact the beneficiary's treatment or management.
- The test will guide treatment and management of a beneficiary already diagnosed with a disease/condition by one or more of the following:
  - Predicting progression, aggressiveness, or recurrence.
  - Selecting specific medications, treatments, and interventions.
- The test will predict a risk of a genetic disease/condition or is necessary to detect an undiagnosed health condition in an asymptomatic beneficiary and the results will directly impact the beneficiary's treatment or management. Coverage of these screening tests is limited to tests recommended as Grade A or B by the United States Preventive Services Task Force (USPSTF) or tests specially identified in Medicaid policy (e.g,. screening for fetal trisomy 13, trisomy 18, or trisomy 21 using noninvasive prenatal testing [NIPT]).

To be eligible for Medicaid reimbursement, the following requirements apply:

- The test must be ordered by a Medicaid-enrolled, licensed physician (MD or DO), physician assistant, or advanced practice registered nurse (e.g., Certified Nurse Practitioner [NP], Certified Clinical Nurse Specialist [CNS], and Certified Nurse-Midwife [CNM]), acting within their professional scope of practice.
- The beneficiary must have one or more of the following:
  - Documented clinical features symptomatic of a disease/condition.
  - A risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation and/or ethnic background.
  - Other disease/condition-specific criteria that places them at risk.
- A physical examination, medical history, family history/pedigree analysis, and conventional diagnostic testing (when appropriate and applicable) must be completed prior to testing.

The clinical utility of all requested genes and gene variants must be established and documented in the beneficiary's medical record regardless of where the test(s) is performed.

Testing is allowed once during the beneficiary's lifetime per disease for diagnostic purposes. If medically necessary, and on a case-by-case basis, PA may be requested to allow for exceptions to this restriction.

Providers must follow state law (Public Act 368 of 1978, Section 333.17020 Genetic test; informed consent) regarding informed consent for predictive genetic testing. This includes any statutory requirements for pre- or post-testing genetic counseling. There must be made available, upon request, documentation of informed consent provided before testing. This documentation must include the limitations of the test, possible outcomes, and methods for communicating and maintaining confidentiality of results.

5.1.A. Test Requirements

A Medicaid-covered genetic or molecular test must:

- Be performed at a Medicaid-enrolled laboratory that is properly certified by CLIA to perform the test.
- Include detected genes, variants, or biomarkers that are shown, by sufficient evidence and scientifically valid methods, to be associated with the risk of, predisposition to, or occurrence of the disease.
- If applicable, utilize a laboratory technology that is a U.S. Food and Drug Administration (FDA)-approved method to identify or evaluate risk for the genetically linked disease/condition, genetic biomarker, or pharmacogenetic variant.
- Have established analytical validity, clinical validity, and clinical utility as evidenced by the following:
  - Clinical performance supported by scientific evidence, peer-reviewed medical literature, definitive or well-established evidence-based guidelines.
  - Test results that can be independently replicated and are attainable outside of investigational settings when used under the usual conditions of medical practice.
  - Test results that provide as much health benefit as established alternatives.
  - Test results that reduce the need for further diagnostic testing or treatment, allow for less intensive treatment due to earlier detection, or help avoid ineffective interventions.

5.2 Authorization Requirements

Authorization is required for most genetic and molecular laboratory tests. (Refer to the Community Health Automated Medicaid Processing System (CHAMPS) Code Rate and Reference tool for authorization necessity.) Authorization requests must be submitted to MDHHS within 30 days of the DOS. Specimen processing should not be completed until after the authorization request has been approved.

Authorization requests require supporting medical documentation relevant to the requested test or a Genetic and Molecular Laboratory Test Authorization Request form (MSA-2081) completed by the beneficiary's Medicaid enrolled treating/ordering provider (i.e., MD, DO, PA, NP). (Refer to the Forms Appendix for a copy of the form, including form completion instructions.) Medical necessity letters submitted as clinical documentation must be beneficiary specific and created and signed by the treating/ordering provider. Generic statements, letters, or order/requisition forms created by the

performing laboratory will not be accepted as a substitute for clinical documentation from the medical record or completion of MSA-2081. The completed MSA-2081 and/or supporting clinical documentation must document the following:

- Indication for the test. Indications should be beneficiary specific and clinical in nature.
- The beneficiary's related signs and symptoms.
- Family history relevant to the beneficiary's condition and test being requested. A family pedigree analysis must be made available upon request.
- Other related testing or clinical findings of the beneficiary or family member.
- How the test results will be used to significantly alter the management or treatment of the disease. This definitive treatment or action plan should be specific to the beneficiary and completed by the provider who will manage the beneficiary using the test results.
- The name and NPI number of the laboratory performing the test.
- The name, specialty, and NPI number of the provider ordering the test.
- Treating/ordering provider signature. Alternatively, a signed laboratory order or requisition or signed medical documentation supporting the clinician's intent to order the test will satisfy the MSA-2081 signature requirement.

5.2.A. AUTHORIZATION SUBMISSION

Authorization requests must be submitted electronically to the MDHHS Program Review Division via Direct Data Entry (DDE) utilizing CHAMPS whenever possible. Providers should enter the request directly into the CHAMPS Prior Authorization Request List page. All authorization requests must include form MSA-2081 and/or supporting clinical documentation. Documents should be electronically uploaded within the Additional Documents section of the CHAMPS authorization request. If the supporting documentation is unable to be uploaded, items may be faxed separately to the MDHHS Program Review Division using the bar-coded fax cover sheet generated by CHAMPS when the fax option is selected. A notation that documentation has been separately faxed should be made in the Procedure Code Comment field of the electronic authorization request. If the correct bar-coded fax cover sheet is not used, faxed documentation may not be associated to the authorization request.

Providers unable to submit authorization requests electronically may submit authorization requests via fax or mail to the MDHHS Program Review Division using the MSA-2081. Providers must include only one authorization request per fax.

The MSA-2081 should be completed by the treating/ordering provider and submitted to MDHHS by the billing (laboratory) provider. The form must be:

- Typed – All information must be clearly typed in the designated boxes; and
- Thorough – Complete information, including the appropriate CPT/HCPCS diagnostic testing procedure codes with applicable modifiers, must be provided on the form. Form MSA-2081 and all documentation must include the beneficiary's name and other

identifying information (i.e., beneficiary identification [ID number] or date of birth [DOB]).

Providers may check the status of an authorization request on the CHAMPS Prior Authorization Request List page. An electronic copy of the determination letter may also be viewed within CHAMPS. A copy of the letter will be mailed to the provider and beneficiary. The letter must be retained in the beneficiary's medical record.

5.2.B. Beneficiary Eligibility

Approval of a laboratory test listed on form MSA-2081 confirms that the service is authorized for the beneficiary. Approval does not guarantee beneficiary eligibility or reimbursement. To ensure payment, the provider must verify the beneficiary's eligibility prior to processing the laboratory specimen.

5.2.C. Billing Authorized Services

After an authorization is issued, the information (e.g., authorization number, procedure code, modifier, and quantity) that was approved must match the information submitted on the claim form.

5.2.D. Reimbursement

Most laboratory services have established fee screens that are published in the MDHHS Laboratory Fee Schedule. For NOC procedure codes and procedure codes without established fee screens, the approved reimbursement amount is indicated on the authorized MSA-2081.

5.2.E. Retroactive Authorization

Laboratory authorizations must be requested within 30 days of the DOS unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS eligibility file does not show that retroactive eligibility was approved, requests for authorization received more than 30 days after the DOS will be denied.

5.3 Genetic Counseling

Medicaid covers medically necessary genetic counseling services as defined in section 333.17001 (Act 368 of 1978) when ordered and performed by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs). Genetic counseling may also be provided by a Medicaid-enrolled licensed Genetic Counselor. Genetic Counselors should refer to the Practitioner chapter for additional information.

Counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Services are considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background.

5.4 Medicaid Health Plans

The genetic and molecular testing standards of coverage, PA, and documentation requirements outlined within this chapter apply to beneficiaries served by Fee-for-Service (FFS) Medicaid. For beneficiaries enrolled in a Medicaid Health Plan (MHP), the provider must check with the beneficiary's plan for coverage and PA requirements.

5.5 Multi-Gene Panels

Medicaid defines multi-gene panels as any assay that simultaneously tests for more than one gene associated with a condition or symptom. The term "gene", when used throughout this section, will be used to indicate a gene, region of a gene, and/or variant(s) of a gene.

Genes assayed on the same DOS will be considered assayed in parallel if the result of one assay does not affect the decision to complete the assay on another gene, and the genes are being tested for the same indication. If a laboratory assays multiple genes simultaneously in parallel, then those genes will be considered part of the same panel. As a panel constitutes a single procedural service, one procedure code must be submitted for the panel. The laboratory should not report multiple individual procedure codes describing the gene component test results.

If a procedure code is available for the multi-gene panel test, this procedure code should be utilized. If no procedure code accurately describes the panel performed, an unlisted molecular pathology or unlisted molecular multi-analyte assay with algorithmic analysis procedure code (as applicable) may be used. When an unlisted procedure code is reported, providers should include the name of the panel test in box 21 of form MSA-2081. The test name should also be reported in the Procedure Code Comment field in the MDHHS CHAMPS authorization form.

Genes assayed on the same DOS will be considered assayed serially when the results of one or more gene analyses determines whether additional analyses are reasonable and necessary. When genes are serially assayed, the laboratory should submit claims with the genes reported individually.

5.6 Rapid Whole Genome Sequencing

Medicaid covers medically necessary rapid whole genome sequencing (rWGS) testing for the evaluation of critically ill infants admitted to an inpatient intensive care unit with a complex illness of unknown etiology. rWGS is medically necessary when all the following apply:

- The beneficiary is one year of age or less;
- The beneficiary's signs or symptoms suggest a rare genetic condition that cannot be diagnosed by a standard clinical work-up;
- The beneficiary's signs and symptoms suggest a broad, differential diagnosis that could require multiple genetic tests if rWGS was not performed;
- Timely identification of a molecular diagnosis is necessary in order to guide clinical decision making, and the rWGS results will guide the treatment and/or management of the beneficiary's condition; and
- At least one of the following clinical criteria apply to the beneficiary:
  - Multiple congenital anomalies

- Specific malformations highly suggestive of a genetic etiology
- An abnormal laboratory test suggests the presence of a genetic disease or complex metabolic phenotype (e.g., abnormal newborn screen, hyperammonemia, or lactic acidosis not due to poor perfusion)
- Refractory or severe hypoglycemia
- Abnormal response to therapy related to an underlying medical condition affecting vital organs or bodily systems
- Severe hypotonia
- Refractory seizures
- A high-risk stratification on evaluation for a Brief Resolved Unexplained Event (BRUE) with any of the following features:
  - Recurrent events without respiratory infection
  - Recurrent witnessed seizure-like events
  - Required cardiopulmonary resuscitation (CPR)
  - Abnormal chemistry levels (e.g., electrolytes, bicarbonate, lactic acid, venous blood gas, glucose) suggestive of inborn error of metabolism
  - Abnormal cardiac diagnostic testing results suggestive of possible channelopathies, arrhythmias, cardiomyopathies, myocarditis, or structural heart disease
  - Family genetic history related to beneficiary's condition

rWGS is not covered when one of the following reasons explains the beneficiary's admission:

- An infection or sepsis with normal response to therapy
- Confirmed prenatal/postnatal genetic diagnosis consistent with the beneficiary's condition
- Hypoxic-Ischemic Encephalopathy (HIE) with a clear precipitating event
- Isolated prematurity
- Isolated Transient Tachypnea of the Newborn (TTN)
- Isolated unconjugated hyperbilirubinemia
- Nonviable neonate
- Trauma
- Meconium aspiration

5.6.A. Provider Evaluation

Prior to ordering rWGS, the beneficiary must be evaluated by a medical geneticist or other physician sub-specialist with expertise in the conditions and/or genetic disorder for which testing is being considered. The consultation must be documented in the beneficiary's medical record and, if performed via telemedicine, should follow all the requirements specified in Medicaid's telemedicine policy.

5.6.B. Test Results

The purpose of rWGS is to identify a molecular diagnosis in a timely manner in order to directly support and impact both acute medical or surgical management and short- and long-term clinical outcomes. rWGS should be ordered when the beneficiary is critically ill and the results are intended to be used in the hospital management of the beneficiary. Generally, a preliminary test report from the performing laboratory should be provided to the beneficiary's ordering physician in less than seven days and a final report in less than 14 days. Hospitals should only utilize laboratories whose average expected turnaround time for rWGS processing meets these established time frames.

5.6.C. Prior Authorization

rWGS requires MDHHS approval. Providers should refer to the Genetic and Molecular Testing section - Authorization Submission subsection in this chapter for submission instructions.

5.6.D. Billing and Reimbursement

Reimbursement for rWGS testing is available to Medicaid enrolled hospitals performing rWGS (directly or through a reference laboratory arrangement) when the test meets Medicaid's coverage guidelines and authorization is obtained. Costs associated with inpatient rWGS testing are excluded from the DRG payment and reimbursement will be made in accordance with the Medicaid laboratory fee screens.

For MHP enrolled beneficiaries, rWGS testing services provided in the inpatient hospital setting prior to discharge are carved-out of the MHPs contract. Such services will be reimbursed by FFS per Medicaid policy.

5.7 Out of State/Beyond Borderland Laboratories

Due to the specialty nature of genetic and molecular services, testing may not be readily available through an in-state laboratory. Genetic and molecular testing performed by an out-of-state or beyond borderland Independent Clinical laboratory is subject only to the clinical PA requirements that would apply if the provider were located in-state. Independent Clinical laboratories performing genetic and molecular testing must designate the "Clinical Laboratory Certified-Genetic Testing" specialty within their CHAMPS provider enrollment record in order to be exempt from Medicaid's out-of-state and beyond borderland provider requirements.

5.8 Non-Covered Services

Genetic and molecular testing is **not** a covered service for:

- Criteria other than those outlined above.
- Establishing a diagnosis or condition that can be diagnosed by conventional diagnostic methods unless conventional testing is not required by Medicaid, or the genetic test is identified as a Grade A or B recommendation by the USPSTF.

- Confirming a diagnosis or condition that was previously diagnosed by another testing method (e.g., conventional testing).
- When the need for the test is not clinically indicated for the beneficiary's condition.
- Purposes where the test results would not directly influence the management or treatment of the disease or condition.
- Informational purposes or management of a beneficiary's family member.
- Testing performed by a second, independent laboratory solely to validate or confirm the beneficiary's previous test results using a methodology designed to detect the same genetic or molecular alteration as the original test.
- Screening or carrier testing for the sole purpose of family planning counseling and/or infertility services.
- Screening for medical research purposes.
- Minors under the age of 18 for adult-onset conditions that have no preventative or therapeutic treatments.
- Testing performed in a non-Clinical Laboratory Improvement Amendments (CLIA) certified laboratory.

SECTION 6 – NONCOVERED SERVICES

Noncovered laboratory services and items include, but are not limited to, the following:

- Laboratory testing not reasonable or medically necessary for the diagnosis or management of the beneficiary's specific condition.
- Services not ordered by the beneficiary's treating provider.
- Laboratory services determined to be not medically necessary by a beneficiary's eligible other insurance benefits (i.e., Medicare).
- Laboratory services for the treatment of infertility, including embryo/sperm collection and banking.
- Repeat tests required because of technical or professional errors in performance of original test or interpretation of test results.
- Any laboratory service the laboratory is not CLIA certified to provide.
- "Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition.

LOCAL HEALTH DEPARTMENTS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all Local Health Departments (LHDs).

1.1 REGULATORY AUTHORITY

A public facility is defined in the following Sections of the Michigan Public Health Code (PA 368 of 1978, as amended):

- Section 333.2413
- Section 333.2415
- Section 333.2421

Local health departments (LHDs) may participate as providers in the Medicaid Program as Public Clinics. Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Section 1902(a)(11) and (22)(C) of the Social Security Act.

A Title V grantee means an agency, institution, or organization that receives federal payments for part or all of the cost of any service program or project authorized by Title V of the Social Security Act, including:

- Children and youth projects;
- Children's Special Health Care Services (CSHCS);
- Maternal and child health services;
- Maternal and infant care projects; and
- Projects for the dental health of children.

1.2 PROVIDER ENROLLMENT

Michigan Department of Health and Human Services (MDHHS) requires all LHDs to have a Type 2 (Organization) National Provider Identification (NPI) number in order to receive the enhanced LHD reimbursement. For LHDs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the LHD fails to obtain and/or use the correct NPI number, the LHD reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS via the on-line CHAMPS Provider Enrollment (PE) subsystem before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

SECTION 2 - BENEFITS

Covered services provided by LHDs include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a public facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

2.1 COVERED SERVICES

LHDs receive full cost reimbursement for the following services:

- Breast and Cervical Cancer Control Program Services
- Child Health and Primary Care Services
- Communicable Disease Services (e.g., Tuberculosis [TB])
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (including blood lead testing and follow-up services)
- Family Planning Clinic Services
- Hearing and Vision Screening
- Home Health (HH) Care Services
- Immunizations
- Maternal and Child Health Lab Services
- Maternal Infant Health Program (MIHP) Services
- Prenatal Care Clinic Services
- Sexually Transmitted Disease Services

2.2 ADDITIONAL INFORMATION ON BLOOD LEAD TESTING

2.2.A. INITIAL BLOOD LEAD TESTING

LHDs are not required to obtain a referral or receive PA to obtain a blood lead sample from Medicaid-covered children through six years of age, whether they are enrolled in a MHP or are FFS beneficiaries. To prevent duplication of services, the LHD must make reasonable effort to assure that a blood lead test has not been obtained by the child's primary care provider (PCP).

All blood lead draws must be provided in compliance with Medicaid policy. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information regarding guidelines for age-appropriate blood lead testing intervals.

The LHD must instruct the laboratory completing the blood lead analysis to send all blood test results to the child's PCP and health plan, if enrolled in managed care. Should a positive test be found, the LHD must collaborate with the PCP to assure the appropriate follow-up care is provided. The PCP is responsible for any additional blood lead testing.

If a capillary blood specimen is obtained, the LHD may bill MDHHS using procedure code 36416 for both MHP enrolled and FFS beneficiaries.

The LHD may send the sample to the State Laboratory for analysis or to any clinical laboratory that is CLIA-certified to perform blood lead analysis. The information accompanying the sample to the laboratory must include the name of the PCP, if known, and the name of the health plan for those children enrolled in managed care.

The LHD may complete the blood lead analysis if they are CLIA-certified to do so. If the LHD completes the blood lead analysis, procedure code 83655 should be billed. The reimbursement includes payment for the capillary or venipuncture blood lead draw.

2.2.B. Blood Lead Poisoning Follow-Up Services

LHDs may provide blood lead poisoning follow-up services which consist of environmental investigations and case management services.

LHDs may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP or is in the FFS program. Authorization for these services is not required by the MHP; however, LHDs must notify the plan of the service(s) provided and provide the plan with a summary of each.

Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and case management services.

2.2.B.1. Case Management Services

Case management services for children with a blood lead reference value (BLRV) of 3.5 µg/dL or greater are covered under the Children's Special Health Care Services (CSHCS) case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)

2.2.B.2. Environmental Investigations

An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. A beneficiary's home is defined as their legal address. The beneficiary's primary residence is a place other than their legal address where the beneficiary spends a significant amount of time. To be eligible for the service, the beneficiary must be under 21 years of age and have a confirmed BLRV of 3.5 µg/dL or greater.

If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. An environmental investigation visit can be billed directly to Medicaid FFS regardless if the

beneficiary is enrolled in a MHP. Reimbursement is limited to the time and activities provided by certified assessors during the on-site investigation.

Environmental investigations must be performed by assessors certified by the Michigan Department of Health and Human Services (MDHHS) Healthy Homes Program. The home or primary residence to be investigated must meet one of the following criteria:

- The home or primary residence was built before 1978.
- A home or primary residence built after 1978 when identification of other possible sources of lead exposure such as a job, hobby, environmental, home remedies, or cultural practices that use lead are associated with the property in question.

The investigation must follow the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques.

Risk assessors must prepare a risk assessment report per rule R325.99404 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.

Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report.

An episode includes a venous blood sample indicating the child is at risk according to recommendations by the Centers for Disease Control and Prevention (CDC), and also includes resulting treatment and follow-up services.

When an environmental investigation of the home finds no sources of lead or insufficient evidence to justify the beneficiary's elevated blood lead level, a second site may be investigated (e.g., home of a family member, relative, or other informal child care where a child often visits). When billing for the second site, local health departments must report the TS modifier with the procedure code on the claim. A maximum of two sites may be investigated.

2.2.C. Blood Lead Resource Documents

Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDHHS Healthy Home Section. (Refer to the Provider Resources section of the Directory Appendix for contact information.)

Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information on blood lead.

2.3 Additional Information on Objective Hearing & Vision Screening

To be eligible to provide and bill for services, all LHD screening staff must be qualified to administer preschool objective hearing and objective vision screening by the MDHHS Public Health Administration. This service coverage is limited to LHD providers when performed either on-site or in the community setting.

Objective hearing screening and objective vision screening may be performed on eligible Medicaid preschool-aged children from age three through six years of age by qualified LHD staff. LHDs may provide objective hearing and/or vision screening services and accept referrals for screening from physicians and from Head Start agencies. The objective hearing and/or vision screening results must be reported to the child's primary care provider (PCP). If the LHD is unable to report the results to the child's PCP, the LHD must clearly document why this could not be accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

2.4 Administrative Services

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

LHDs providing Medicaid administrative services should report costs for these services on their quarterly Financial Status Report in accordance with federal regulation to qualify for Federal matching funds. These reports must be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. Questions regarding reimbursement of administrative services should be directed to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

Refer to the Medicaid Outreach Activities section for reporting requirements, and billing and reimbursement information related to outreach activities.

2.5 Medicaid Health Plan Services

LHDs must obtain PA from a Medicaid Health Plan (MHP) for any Medicaid covered service provided to a Medicaid beneficiary enrolled in a health plan **except** for the following services:

- Immunizations
- Sexually Transmitted Disease (STD) services
- TB Diagnosis and Treatment
- Family Planning Services
- Blood lead draws for children through six years of age
- Hearing and vision screening

Except for blood lead draws, payment for covered services is based on the terms of the contract between the LHD and health plan if the LHD and a MHP have entered into a contract. In the absence of a contract, payment is based on the Medicaid fee-for-service (FFS) rates in effect on the date of service (DOS). Medicaid encourages contractual relationships between these entities.

LHDs must bill the MHP directly for immunizations provided to beneficiaries enrolled in managed care. Any claims billed to the Community Health Automated Medicaid Processing System (CHAMPS) for MHP members will be denied.

The following out-of-plan services performed by the LHD can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP:

- Blood lead draws
- Lead investigations and follow-up services
- Hearing and vision screenings

SECTION 3 – MEDICAID OUTREACH ACTIVITIES

3.1 ALLOWABLE ACTIVITY CATEGORIES

Local Health Departments may perform the following Medicaid outreach activities and receive reimbursement through their Comprehensive Planning, Budgeting and Contracting (CPBC) Grant Agreement with MDHHS.

All outreach activities must be specific to the Medicaid program. In addition, activities that are part of a direct service are not claimable as an administrative service.

3.1.A. MEDICAID OUTREACH AND PUBLIC AWARENESS

Informing Medicaid eligible and potentially Medicaid eligible children and families about the benefits and availability of services provided by Medicaid.

This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums.

Examples of activities in this category include, but are not limited to:

- Developing, compiling, and/or distributing materials that inform individuals about the Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and how and where to obtain benefits.
- Contacting pregnant and parenting women about the availability of Medicaid services, including referral to family planning and well-baby care programs and services.

Examples of activities that are not appropriate for this category include, but are not limited to, Women, Infants, and Children (WIC) and Maternal Infant Health Program (MIHP) staff providing referral information about available health and community services. The State of Michigan mandates that these services be provided as a condition of operating the program.

3.1.B. FACILITATING MEDICAID ELIGIBILITY DETERMINATION

Activities related to assisting potentially Medicaid-eligible individuals in applying for Medicaid benefits.

This includes explaining the Medicaid program to individuals or families, providing a Medicaid application form, assisting an individual in completing a Medicaid application, and/or referring individuals to the local MDHHS office for determination of benefits. Community health workers may act as client advocates when additional assistance is needed to complete the application process. Community health workers can also help clients overcome other barriers such as linguistic, cultural, and cognitive challenges to the application and enrollment process.

Examples of activities in this category include, but are not limited to:

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.

Examples of activities that are not appropriate for this category include, but are not limited to:

- Verifying an individual's current Medicaid eligibility status for a direct service or billing of medical appointment.
- Explaining the eligibility process for non-Medicaid programs.

3.1.C. Program Planning, Policy Development, and Interagency Coordination Related to Medical Services

Development of health programs and services targeted to the Medicaid population and collaboration between the LHD and other agencies to ensure the delivery of Medicaid-covered services.

Activities in this category only apply to LHD staff whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities. This includes planning and developing procedures to track requests for referrals and coordinating services with the Medicaid Health Plans.

Examples of activities in this category include, but are not limited to:

- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to additional Medicaid populations, increase provider participation, and improve provider relations.
- Enhancing, improving, or streamlining health care service delivery systems in the community.
- Representing the LHD on a committee or task force that is intended to improve access to Medicaid programs and services.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Developing procedures for tracking families' requests for assistance with non-Medicaid services and the providers of such services.
- Creating a collaborative of health professionals to provide consultation and advice on the delivery of health care services to the non-Medicaid population.

3.1.D. Referral, Coordination and Monitoring of Medicaid Services

Making referrals for, coordinating access to, and/or monitoring the delivery of Medicaid services. Working with Medicaid providers to improve the coordination and delivery of clinical health care services, expand access to specific Medicaid populations, and improve collaboration around early identification of medical/dental problems.

Examples of activities in this category include, but are not limited to:

- Making referrals for and/or scheduling appropriate Medicaid-covered services for Medicaid-enrolled individuals.
- Developing referral sources for the LHD, such as a list or brochure of the physicians, dentists or Health Maintenance Organizations (HMOs) in the area who accept Medicaid patients for evaluation or treatment, or a list of other health agencies providing Medicaid services.
- Monitoring or coordinating the completion of the prescribed services, the termination of services, and the referral of the individual to other Medicaid services as necessary.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Conducting quality assurance reviews when MDHHS requires the reviews as a condition of operating the program.
- Making referrals for, and coordinating access to, non-Medicaid services, such as child care, employment, job training, food assistance, and housing.
- Activities that are an integral part of or an extension of a direct medical service.

3.1.E. Medicaid-Specific Training on Outreach Eligibility and Services

Outreach activities that focus on coordinating, conducting, or participating in training and seminars for staff and/or contractors regarding the Medicaid program and available services, the benefits of the program, and how to assist families in accessing Medicaid services.

These include trainings that enhance early identification, screening, and referral of children and adolescents for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. This category also includes development and presentation of training modules regarding Medicaid eligibility and benefits to LHD staff.

Examples of activities in this category include, but are not limited to:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Attending or participating in a Medicaid Outreach inservice or webinar.
- Developing, participating in, or presenting training that addresses the clinical importance of pediatric or other clinical standards for preventive care offered through the Medicaid program.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Participating in or coordinating training that improves the delivery of general LHD services.
- The time spent determining if a specific task can be considered Medicaid outreach.

3.1.F. Arranging for Medicaid-Related Transportation

Assisting an individual in obtaining transportation for Medicaid-related services. NOTE: This does **not** include activities that contribute to the actual billing of transportation as a medical service.

Examples of activities in this category include, but are not limited to:

- Scheduling or arranging transportation to and from Medicaid-covered services for a Medicaid-enrolled individual.
- Assisting or arranging for transportation for the parent/guardian of a Medicaid-enrolled individual in support of the referral and evaluation activities.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Transporting or accompanying a Medicaid-enrolled individual to a medical appointment.
- Assisting an individual in obtaining transportation for non-Medicaid services.

3.1.G. Arranging for or Providing Medicaid-Related Translation Services

Arranging for or providing translation services related to a Medicaid-covered service when translation services are not included and/or paid for as part of a direct medical assistance service.

Examples of activities in this category include, but are not limited to:

- Arranging for or providing translation services (oral or signing services) to assist an individual with completing a Medicaid application.
- Arranging translation services that assist an individual in understanding the Medicaid services available.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Developing translation materials that assist individuals in accessing and understanding non-Medicaid programs and services.
- Arranging for or providing translation services (oral or signing services) that assist the individual in accessing non-Medicaid services.

- Providing translation services to assist a Medicaid-enrolled individual in communicating as part of a direct medical service.

3.2 Documentation and Reporting Requirements

Documentation maintained in support of administrative claims must be sufficiently detailed to allow determination of whether the activities were necessary for the proper and efficient administration of the Medicaid State Plan. The LHD is responsible for all claiming determinations.

LHDs that bill for Medicaid Outreach Activities are expected to provide a quarterly summary report of Medicaid outreach activities. Guidelines and reporting requirements are described in the Comprehensive Agreement.

3.3 Billing and Reimbursement

3.3.A. Grant Agreement

The CPBC Grant Agreement includes the Medicaid Outreach Activities provision. This provision is part of the standard CPBC Grant Agreement language.

Each fiscal year, MDHHS will identify Medicaid outreach priorities. LHDs that bill for Medicaid outreach activities must focus, at a minimum, on one of the identified outreach priorities.

3.3.B. Billing

The LHDs bill for these outreach activities on a quarterly basis in a single column on a Financial Status Report (FSR). The column should be titled Medicaid Outreach Activities. The FSR is part of the LHDs quarterly CPBC FSR submission to MDHHS. MDHHS aggregates all of the quarterly amounts billed for LHD Medicaid outreach activities and submits a claim for the federal portion of the costs. MDHHS reimburses the LHDs after MDHHS receives the reimbursement of the federal claim.

These Medicaid Outreach Activities are claimed at the 50% administrative match rate.

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

3.3.C. Cost Allocation Plans

MDHHS requires LHDs to certify that their existing cost allocation plan is in compliance with OMB Title 2 CFR Part 200 and that the plan identifies Medicaid outreach activities as a specific element of the plan. The certification is accepted by MDHHS as documentation to continue this administrative claiming. Each cost allocation plan is subject to MDHHS review for compliance with OMB Title 2 CFR Part 200.

3.3.D. CERTIFICATIONS

The LHD Cost Allocation Plan certifications are kept on file and should be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

New certifications are required if a modification occurs in the LHD's cost allocation plan that impacts the Medicaid Outreach Activities element or upon a Department review that results in a finding of non-compliance. If neither of these conditions exist, the certification remains valid in subsequent fiscal years.

SECTION 4 – ENCOUNTERS

Encounters are counted and reported by LHDs on the Michigan Medicaid Local Health Department (LHD) Cost Report in order to receive full cost reimbursement. The reported encounters include the health department's total facility encounters, minus dental encounters and, as a subset of total encounters, the total Medicaid encounters at the LHD clinic.

In order to determine a rate per encounter, the total costs of facility services are divided by the total encounters, resulting in a rate per encounter. The rate per encounter is multiplied by the number of Medicaid encounters to determine the total Medicaid costs to be reimbursed.

4.1 DEFINITION OF ENCOUNTER

An encounter is a face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the health service must be recorded in the patient's record.

The following examples help to understand and define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be practicing within the scope of practice defined in the Michigan Public Health Code. The provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and/or dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by medical or other health providers which do constitute encounters.
- A provider may be credited with no more than one encounter with a given patient during a single day, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. For example, when a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg, then visits may be classified as two encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.

- The following services are not classified as encounters:
  - Allergy injection(s)
  - Collecting urine specimens
  - Dispensing prescriptions
  - Drawing a blood sample
  - Filling out insurance forms, etc.
  - Performing laboratory tests
  - Refilling prescriptions
  - Taking a history
  - Taking vital signs
  - Taking x-rays

4.2 Medicare/Medicaid Encounters

Services for Medicare and Medicaid dual beneficiaries are eligible for full cost reimbursement, and these encounters are considered Medicaid encounters.

4.3 Other Insurance Encounters

Medicaid services provided to beneficiaries with other commercial health insurance carriers are eligible for full cost, and the encounters are considered Medicaid encounters. Medicaid requires beneficiaries' other insurance resources and their network providers to be utilized for all services covered under the private coverage before billing Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would pay, providers must still bill the procedure code and enter the other insurance payment on the claim. The claim showing other insurance reimbursement or zero payment must be processed through the claim system in order to be counted as a Medicaid encounter. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

SECTION 5 – PUBLIC DENTAL CLINIC ENHANCED REIMBURSEMENT RATE

5.1 GENERAL INFORMATION

Public Dental Clinics are paid at the average commercial rate for Medicaid dental services. Qualifying providers include any Public Dental Clinic as identified in one of the following sections of the Michigan Public Health Code (PA 368 of 1978 as amended): 333.2413, 333.2415, or 333.2421.

5.2 RATE DETERMINATION

The average commercial rate is determined by MDHHS staff through information supplied by the commercial dental insurers and paid to providers eligible for this supplemental payment. If this information is not available from the commercial carriers, MDHHS may determine the rate from other sources.

5.3 PAYMENT METHODOLOGY

Public dental clinics submit claims and receive payment based on MDHHS fee-for-service (FFS) rates throughout the year. MDHHS identifies services and payments from Medicaid paid claims records at the end of the public dental clinic's fiscal year. An annual settlement calculation is performed to determine the difference between the Medicaid fee screen payments and the average commercial rate.

This calculation and a notice are sent to the public dental clinic indicating the amount of local share that must be received from the public dental clinic. The local share must be received prior to the submission of the federal claim. The local share is sent from the public dental clinic to MDHHS via the Intergovernmental Transfer process. After receipt of the local share, MDHHS will process a payment to the public dental clinic for the entire amount of difference between the FFS payments and the average commercial rate. The settlements are performed for each public dental clinic for each fiscal year.

MDHHS may pay interim payments for the estimated difference between Medicaid FFS payments and the average commercial rate. Interim payments will be reconciled at the time of annual settlement.

Settlements do not apply to services for which primary reimbursement is the responsibility of the Dental Health Plan (DHP) through the ***Healthy Kids Dental*** contract or any other third party payer.

The enhanced reimbursement rate process is in place of the cost-settlement process for dental encounters.

SECTION 6 – COST REPORTING REQUIREMENTS

6.1 FULL COST METHODOLOGY

The term full cost reimbursement, as used in this chapter, means the cost of providing Medicaid services as determined by information provided on the Michigan Medicaid Cost Report for LHDs. Full cost is derived from the amounts the LHD receives from Medicaid Fee-for-Service and Medicaid Health Plan payments, other third party insurers, quarterly payments from MDHHS, and initial and final settlements. A combination of local and state general funds provides the basis for full cost reimbursement and is used for claiming federal financial participation. MDHHS will reimburse the LHD for its services, other than dental services, at reasonable and allowable actual incurred costs according to 42 CFR § 431.615(c)(4).

To receive full cost reimbursement, qualified providers must supply the MDHHS Hospital and Clinic Reimbursement Division (HCRD) with a Michigan Medicaid cost report.

6.2 COST SETTLEMENTS

Cost settlements are performed annually to ensure that the payments were made at reasonable and allowable full cost. As necessitated by the cost settlement process, any financial adjustments are made with the LHD. Settlements are performed for each LHD for each fiscal year.

6.3 REASONABLE AND ALLOWABLE COSTS

Reasonable and allowable costs are determined using the applicable Medicare cost reimbursement principles detailed in 42 CFR, Part 413.

6.4 FILING COST REPORTS

LHDs must file a Michigan Medicaid cost report with the MDHHS HCRD annually. The authorized individual must sign the cost report and related Medicaid supplemental documents. The LHD cost report is due five months after the end of the normal fiscal period.

- A 30-day extension of the due date may, for good cause, be granted if a written request is received by the HCRD prior to the expiration of the original five months.
- The LHD cost report may be filed for more or less than an annual period only when necessitated by facilities terminating their agreement with MDHHS, by a change in ownership, or by a change in fiscal period.

Improperly completed or incomplete filings are returned to the LHD for proper completion and must be resubmitted to MDHHS within 30 days of receipt of the cost report.

If the required cost report and supplemental documents are not submitted within the required time limit (including approved extensions), no cost settlement for full cost reimbursement occurs for that fiscal period. By not submitting a cost report, it is understood that the LHDs are withdrawing from the full cost program. This action remains in effect until proper submission of all the required documents in a subsequent fiscal period.

If LHDs do not file a cost report, any interim payments are recovered for the year in which the LHD did not participate in the full cost reimbursement program.

6.5 Amending Cost Reports

LHDs may amend a cost report by requesting the amendment in writing and submitting a revised cost report to the MDHHS HCRD. The revised cost report must be submitted no later than one year from the original filing date. The letter must explain why the cost report requires revision, and how it was changed.

6.6 Accounting and Record Keeping

Each LHD operating a clinic in the State of Michigan and seeking payment under the LHD provisions must complete LHD cost reports.

Medicaid supplemental documents must be filed using the modified accrual method of accounting. These documents must be forwarded to MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

The LHD must maintain, for a period of not less than seven years from the end of the fiscal year of the LHD cost report, financial and clinical records for the period covered by the cost report which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved issues at the end of this seven-year period, the records must be maintained until these issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the LHD or they are disallowed.

The MDHHS HCRD maintains each required LHD cost report and supplemental documents submitted by the provider for seven years following the date of submission of the report. In the event there are unresolved issues at the end of this seven-year period, the cost report is maintained until such issues are resolved.

Financial and clinical records of the LHD must be available for review by authorized personnel of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, or the U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act.

SECTION 7 – INTERIM PAYMENTS, SETTLEMENTS AND APPEALS

7.1 SETTLEMENT(S) OF LOCAL HEALTH DEPARTMENTS

An initial settlement is calculated annually from the cost of providing Medicaid covered services to Medicaid beneficiaries enrolled in the FFS program and MHPs. Calculations are determined from the filed Medicaid LHD cost report.

FFS encounters are verified for the cost settlement from the MDHHS paid claims data. Encounters for MHP or private HMO enrollees are recorded in the cost report. An initial settlement generally is completed within three months of the receipt of a complete and acceptable cost report. MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

Final settlements for LHDs generally are completed within one year of the fiscal year end using updated Medicaid data for the period covered by the LHD cost report. This allows sufficient time for all claims to clear the MDHHS payment system. Medicaid data is updated using MDHHS approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

Settlements with amounts due to the LHD are paid with a payment voucher. Settlements showing an overpayment to the LHDs must be repaid to the State of Michigan as noted in the settlement letter.

7.2 AUDIT ADJUSTMENT REPORT

An Audit Adjustment Report showing adjustments to the filed cost report is sent with the final settlement. If the LHD accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the LHD signs the report and mails the report to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

7.3 MEDICAID PROVIDER APPEALS

Medicaid providers have the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). Appeals must be submitted in writing and mailed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

The appeals process is outlined in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended. Any questions regarding the appeal process should be directed to MOAHR.

MATERNAL INFANT HEALTH PROGRAM

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SECTION 1 - GENERAL INFORMATION

This chapter applies to certified Maternal Infant Health Program (MIHP) providers servicing Medicaid and Maternity Outpatient Medical Services (MOMS) beneficiaries. The purpose of MIHP is to reduce infant mortality and morbidity. This is an objective of both the State of Michigan and the federal government who fund this program. The goal of the MIHP is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development.

Accordingly, MIHP services are intended to help pregnant Medicaid beneficiaries who are most likely to experience serious psychosocial or nutritional issues. Services are intended to supplement regular prenatal/infant care and to assist the following providers in managing the beneficiary's health and well-being:

- Physicians (MD, DO)
- Certified Nurse Midwives
- Pediatric Nurse Practitioners
- Family Nurse Practitioners
- Medicaid Health Plans
- Physician Assistants

This chapter is designed to work with the Maternal Infant Health Program Operations Guide, developed and maintained by the MDHHS Division of Family & Community Health. The Guide is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.1 PROGRAM SERVICES

MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Health and Human Services (MDHHS). MIHP services are provided by a licensed social worker and a licensed registered nurse. Licensed social workers and licensed registered nurses who are certified as an Internationally Board Certified Lactation Consultant (IBCLC) may provide services. An infant mental health specialist with an Infant Mental Health endorsement may be included. A registered dietitian may also provide services with a physician order. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.

Program services include social work, nursing services (including health education and nutrition education), breast feeding support, nutritional counseling, and beneficiary advocacy services. MIHP services include:

- Psychosocial and nutritional assessment
- Plan of care development
- Professional intervention services

- Maternal and infant health and nutrition education
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments
- Referral to community services (e.g., mental health, substance abuse)
- Coordination with other medical care providers and Medicaid Health Plans (MHPs)
- Family Planning education and referral
- Coordinating or providing childbirth or parenting education classes

1.2 Staff Credentials

MIHP staff consists of registered nurses and licensed social workers with the following qualifications:

Nurses	All nurses must possess: ▪ current Michigan licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs; and ▪ at least one year of experience providing community health, pediatric or maternal/infant nursing services.
Social Workers	All social workers must possess: ▪ current Michigan licensure as a licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and ▪ at least one year of experience providing Social Work services to families.

Other professionals who may provide services must have the following qualifications:

Infant Mental Health Specialist	▪ Current Michigan licensure as a psychologist, master social worker, or professional counselor by the Michigan Department of Licensing and Regulatory Affairs; ▪ Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), demonstrating competency at the Infant Mental Health Specialist level; and ▪ At least one year of experience in an infant health program.
Internationally Board Certified Lactation Consultant (IBCLC)	All IBCLCs must possess: ▪ current Michigan licensure as a registered nurse or licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and ▪ credentialing by the International Board of Lactation Consultant Examiners (IBCLE) and a valid and current IBCLC certification.

Registered Dietitian	▪ A Master's Degree in Public Health with emphasis in nutrition or a Master's Degree in human nutrition; or ▪ a Bachelor's Degree and registration as a dietitian (RD); or ▪ a Bachelor's Degree and RD-eligible with examination pending in six months or less; and ▪ at least one year of experience providing community health, pediatric, and/or maternal/infant nutrition services. A physician order is needed before the dietitian may provide services.

A physician order must be obtained before a registered dietitian may visit with the beneficiary. The physician order must be included in the beneficiary record. If community resources are available, such as a hospital dietitian, the MIHP may coordinate with the physician to refer the beneficiary to the hospital dietitian. The MIHP may also coordinate nutrition services with the MHP. When nutrition counseling is needed, the documentation must indicate how services were provided. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.

1.3 Eligibility

Maternal Services	Pregnant Medicaid beneficiaries qualify for MIHP services at any time during the pregnancy. After delivery, a new maternal MIHP case cannot be opened. Maternal services remaining after birth may be provided up to 12 months postpartum and are dependent on maternal eligibility.
Infant Services	MIHP services for an infant begin after the infant's birth and hospital discharge. Infant services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family.
Both Maternal and Infant Services	An infant case and a maternal case can both be open at the same time in some incidences. If the MIHP is seeing an infant and the mother becomes pregnant, a maternal risk identifier assessment visit can be completed and billed as such. After this initial risk identifier assessment visit is completed, all subsequent professional visits for that family should be blended visits and billed under one Medicaid ID. The program is based on the family dyad, and both the infant and parent are to be assessed at each visit and billed as "blended visits" under either the parent's or the infant's Medicaid ID.

1.4 Medicaid Health Plans (MHP)

MIHP services provided to individuals enrolled in a MHP are administered by the MHP in adherence to the program components as outlined in this chapter. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs.

1.4.A. Contractual Agreements

MIHP providers must establish and maintain provider contractual agreements with the MHPs in their service area to receive payment for in-network services provided to MHP

enrollees unless the MHP indicates otherwise. MIHP providers are encouraged to contract with the MHPs in their service area.

1.4.B. Care Coordination Agreements

MIHP providers are encouraged to establish Care Coordination Agreements (CCAs) with all MHPs in their service area. MIHP providers and MHPs must also establish and maintain a CCA for in-network and out-of-network services. The intent of the CCA is to explicitly describe the services to be coordinated and essential aspects of collaboration between the MHP and the MIHP provider. (Refer to the Forms Appendix for an example of a Care Coordination Agreement.)

1.4.C. Freedom of Choice

MIHP services are voluntary and participants must be allowed the freedom of choice of MIHP providers, including the opportunity to: select an in-network provider; maintain a current service relationship which extends services to the infant by the same provider who rendered maternal services; change providers within the MHP network of providers; or decline services.

1.4.D. Referral to an MIHP

Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services. This may be evidenced by enrollee self-attestation. MHPs may be required to present MDHHS evidence of MIHP referral and care coordination, evidence of participation in an equivalent evidence-based home visiting program, or refusal of MIHP services upon request.

1.4.E. Prior Authorization of Services

MHPs may not require prior authorization for the Initial Risk Assessment visit, professional visits, drug-exposed infant visits, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in policy. MIHP services in excess of limits established in policy may be subject to MHP prior authorization requirements.

1.4.F. Out-of-Network MIHP Services

It is incumbent upon MIHP providers to check eligibility and MHP enrollment at every visit. Relationships established during previous pregnancies with out-of-network MIHP providers are not required to be covered by the MHP. Non-contracted MIHP providers, including those who have a current MIHP relationship with a pregnant woman or infant, are required to contact the enrollee's MHP to discuss operational details before providing out-of-network services.

SECTION 2 - PROGRAM COMPONENTS

The assessment visit is the initial visit with the beneficiary. It is conducted with the beneficiary by either a registered nurse or licensed social worker. The assessment visit should be billed using the appropriate place of service code.

The Risk Identifier is a mandatory tool utilized during the assessment visit. The Risk Identifier assures all appropriate services are identified prior to initiation of professional visits, child birth education, parenting education or transportation services. If a Risk Identifier indicates a need for MIHP services, an appropriate Plan of Care (POC) must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). The Risk Identifier and the POC must be completed and the Risk Identifier entered into the MIHP database before further MIHP services are initiated.

If the Risk Identifier does not indicate the need for MIHP services or when, after completion of the Risk Identifier the beneficiary refuses services, then the POC is not developed and the Discharge Summary is completed accordingly. No follow-up services should be provided; however, the beneficiary should receive the informational packet. (Refer to the Maternal Infant Health Program Operations Guide for additional information.)

2.1 MATERNAL RISK IDENTIFIER

The Maternal Risk Identifier covers multiple domains, including basic care, drug and alcohol use, smoking, shelter, depression, transportation needs, intent to breast feed, and support systems. The Maternal Risk Identifier can be found in the Maternal Infant Health Program Operations Guide. It must be completed for each pregnant woman to determine the services needed through the MIHP. Either the licensed social worker or the registered nurse must work with the beneficiary to complete the form. MIHP services will be provided based on the beneficiary's responses to the various questions on the Maternal Risk Identifier. The Maternal Risk Identifier must be completed to assure all appropriate services are identified. Reimbursement for the Maternal Risk Identifier is limited to one Maternal Risk Identifier for each eligible Medicaid beneficiary for each pregnancy.

The Maternal Risk Identifier results must be entered into the MIHP database. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) The MIHP database will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and the licensed social worker, working together, must write a plan of care to determine appropriate interventions. The initial assessment visit and up to nine professional visits per woman per pregnancy are billable. The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the pregnant woman within 14 calendar days after the referral is received.

MIHP serves the maternal/infant dyad. When infant services are initiated, an Infant Risk Identifier must be completed.

2.2 INFANT RISK IDENTIFIER

The Infant Risk Identifier, as found in the Maternal Infant Health Program Operations Guide, must be completed for each infant entering the MIHP to determine the services needed. Either the licensed social worker or the registered nurse must work with the beneficiary and primary caregiver to complete the

form. The Infant Risk Identifier is made up of many domains, including health and safety, feeding and nutrition, family support, child care, and general growth and development. MIHP services will be provided based on the responses to the various questions on the Infant Risk Identifier.

The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the beneficiary within a maximum of seven calendar days for the infant. For referrals received prior to the infant's discharge from the inpatient setting, the Risk Identifier should be conducted within two (2) business days following the hospital discharge. If the MIHP provider is unable to visit the beneficiary within the stated time frame, documentation must clearly support all attempts to contact or visit the infant beneficiary.

When infant services are initiated, an Infant Risk Identifier may be billed as a separate visit from a maternal postpartum professional visit when these services are performed on the same date of service. Documentation must substantiate why it was necessary to perform both visits on the same date of service. Servicing the maternal/infant dyad, all subsequent visits for that family should be "blended visits" and billed as "blended visits" under either the mother's or the infant's Medicaid ID.

The Infant Risk Identifier must be entered into the MIHP database. The system will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and the licensed social worker, working together, must write a plan of care for each beneficiary.

The initial assessment visit and up to nine professional visits per infant/family are billable. An additional nine infant visits may be provided when requested in writing by the medical care provider. All visits beyond the original nine visits must have a written physician order. The reason for and purpose of additional visits must be well documented in the medical record.

2.3 Multiple Births

In cases of multiple births, each infant should have a separate risk identifier visit completed. This also applies to infants in foster care where there are two infants in the same home. These separate risk identifier visits can be billed separately under each individual infant Medicaid identification number. Subsequent professional visits should be billed under each infant ID if the infants are from different families, such as with foster care families. If the infants are siblings, the visits should be "blended visits" and billed under one Medicaid ID only. The risk identifier visit and up to nine professional visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family.

2.4 Psychosocial and Nutritional Assessment-Risk Identifier

The MIHP consists of many interventions in multiple domains designed to educate and inform the beneficiary, both as a pregnant woman and as the parent of an infant. Domains include basic care, physical abuse, substance abuse, social behavior and health history. The Risk Identifiers are designed to determine if there is high, medium, low, or no risk for each domain. Based on the Risk Identifier and professional observation, the MIHP provider will determine interventions specific to each beneficiary. Refer to the Maternal Infant Health Program Operations Guide for more information and interventions related to the domains.

If the Risk Identifier does not indicate the need for MIHP services, then no follow-up services should be provided; however, the beneficiary should receive the informational packet. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) If a need is indicated, an appropriate POC

must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). If a MIHP prenatal case subsequently becomes an MIHP infant case, the Infant Risk Identifier must be completed to determine eligibility for the infant before professional visits are made.

The beneficiary must be assessed (Risk Identifier completed) for the need for transportation assistance, childbirth/parenting education classes, health education, breast feeding support, and family planning services. The completion of the Risk Identifier must precede any professional or IBCLC visits. The Risk Identifier must be completed by the licensed registered nurse or the licensed social worker.

2.5 Plan of Care

The registered nurse and the licensed social worker, working together, must develop a comprehensive POC to provide identified services to the beneficiary and/or referrals to community agencies. The POC must indicate the specific domains at risk, the specific objectives, specific intervention(s) to be implemented, and the number of visits that are required for actualizing the plan. The POC must be updated whenever a significant change occurs. Documentation must support the changes made. The MIHP provider must determine how best to involve the registered nurse and the licensed social worker in implementing the POC based on the needs identified.

The POC must identify if a beneficiary would benefit from a visit with a registered dietitian based on the needs identified. If the services of a registered dietitian are needed, the necessary physician order must be obtained. The beneficiary may be referred to their MHP or local hospital for nutritional counseling.

The beneficiary's exit from the program is expected to occur when the objectives of the POC are complete, or when the MIHP provider determines that continued interventions are no longer needed.

2.6 Care Coordinator

A specific registered nurse or licensed social worker will be identified as the care coordinator assigned to monitor and coordinate all MIHP care, referrals, and follow-up services for the beneficiary. The care coordinator must assure the family is appropriately followed and referred for needed services. The name of the care coordinator must be documented in the beneficiary's record. The care coordinator must refer all beneficiaries to the Women, Infants and Children (WIC) Program if they are not receiving WIC.

For the infant, MIHP providers are encouraged to participate in local Children's Protective Services (CPS) Interdisciplinary Team meetings, Part C/Early On Interagency Coordinating Council meetings, and in similar efforts to coordinate the infant's care. This assures the use of and coordination with other community resources to avoid duplication of services, identify gaps, and to assure ongoing support when the MIHP case is closed. When appropriate, MIHP referrals to CPS must be made. Appropriate family planning education and referrals must be made and documented.

2.7 Professional Visits

A professional visit is an encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) for the specific purpose of implementing the beneficiary's plan of care. A registered dietitian may conduct a visit when ordered by a physician.

The professional visit, additional home visit, and discharge visit are one-on-one visits that must be scheduled to accommodate the beneficiary's situation and be appropriate to the beneficiary's level of understanding. Visits lasting less than 30 minutes or provided in a group setting are not billable.

Medicaid reimbursement for a professional visit includes related care coordination activities. MIHP providers are eligible for Medicaid reimbursement for one professional visit per beneficiary on the same date of service, regardless of the place of service. When beneficiary needs arise, the MIHP provider must coordinate all necessary MIHP related services with the appropriate community agencies. Visits beyond the established limit cannot be billed to the beneficiary or Medicaid.

All professional visit records must include the place of service, time the visit began and ended, risk factors discussed, and actions taken. Coordination of agency and community services and arranging transportation for the beneficiary are part of each professional visit. The MIHP provider must assure the beneficiary has been referred to the WIC program.

Family planning options must be discussed throughout the course of care, giving the woman time to consider their options.

The MIHP must provide directly or arrange bilingual services and/or services for the visually impaired and/or hearing impaired when needed so all beneficiaries may fully participate in the MIHP.

MDHHS does not reimburse for missed visits/appointments. A beneficiary may not be billed for a missed visit/appointment.

2.8 Enhanced Care Coordination Time

This time must only be reported by the care coordinator. Enhanced care coordination time includes all hours spent on provider office-based phone calls, referrals, and non-face-to-face interactions concerning beneficiary services and support. This time must be reported when at least 30 minutes of MIHP home visitor time is dedicated to care management activities within a single calendar month.

2.9 Drug-Exposed Infant

A drug-exposed infant is an infant born with the presence of an illegal drug(s) and/or alcohol in their circulatory system, or who is living in an environment where substance abuse and/or alcohol is a danger or is suspected. Due to the complex nature of these cases, additional visits may be required. A separate drug-exposed procedure code is assigned for additional visits. The beneficiary's record must contain documentation to support the use of the drug-exposed procedure code.

The initial assessment and up to nine professional visits for a drug-exposed infant are billable by the MIHP. An additional nine infant visits may be provided when requested in writing by the medical care provider. In these cases, the reason for and purpose of additional visits must be well documented in the beneficiary record.

The maximum of 36 professional visits and the initial assessment visit may be reimbursed for a drug-exposed infant. The provider must use the professional visit code for the first 18 visits; the drug-exposed procedure code may then be billed for up to an additional 18 visits. Refer to the MDHHS website for additional code information. (Refer to the Directory Appendix for website information.)

In instances where a request is made for additional visits for a drug-exposed infant, the MIHP provider may, when deemed necessary and substantiated by appropriate documentation, substitute the drug-exposed procedure code with the complex home visit code. This substitution will still be considered one of the 18 allowable additional visits for the beneficiary and must be drug exposure related. Furthermore, the total number of professional visits, in addition to the initial assessment visit, shall not exceed the maximum limit of 36 visits.

2.10 Place of Service

Reimbursement for professional visits is based on the place of service. A clinic/office visit and a home visit pay different amounts; therefore, the place of service must be documented in each professional visit note.

Typically, all visits are performed at the beneficiary's home or at the MIHP provider's office. On rare occasions when a visit cannot be completed in the beneficiary's home, in the provider's office or via telehealth, the provider may work with the beneficiary to identify a mutually agreeable site to conduct a visit. These types of visits are referenced as visits occurring in the community setting.

For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in their home or in the MIHP office setting. This documentation must be completed for each visit occurring in the community setting. Visits occurring in buildings contiguous with the provider's office, in the provider's satellite office, or rooms arranged or rented for the purpose of seeing beneficiaries are considered to be in an office setting rather than in a community setting. Visits should never be conducted in the MIHP provider's home.

2.10.A. Maternal Services

- Professional visits may be provided in a clinic/office setting, the beneficiary's home/place of residence, including homeless shelter, via telehealth, or at a mutually agreed upon community location. Efforts must be made to visit the beneficiary in the home.
- Professional visits may not be provided in the inpatient hospital setting.

2.10.B. Infant Services

- MIHP is a home-visiting program.
- If a home visit is not feasible, services may be provided any place other than an inpatient hospital setting.
- The infant and primary caregiver must be present at all visits.

2.10.C. Telehealth Services

MIHP agencies may conduct initial assessment visits and professional visits via telehealth. Agencies will be allowed to provide a maximum of up to 40 percent of their total caseload of visits as telehealth, while 60 percent of visits must remain as in-person visits. This percentage is applied to the agency and not per beneficiary to allow for telehealth visit flexibility dependent on beneficiary needs.

Telehealth visits must include a dual audio/visual platform. Providers must ensure the privacy of the beneficiary and the security of any information shared via telehealth. MDHHS requires either direct or indirect beneficiary consent for all services provided via telehealth. This consent must be properly documented in the beneficiary's chart in accordance with applicable standards of practice. Telehealth visits must follow policy guidelines and program requirements for typical MIHP initial assessment and professional visits.

Appropriate use of telehealth will be determined by a combination of beneficiary preference and MIHP provider judgement. Examples of when telehealth is an appropriate option may include, but are not limited to, circumstances such as when a beneficiary:

- Refuses an in-person visit and would benefit from receiving MIHP services,
- Has an illness in their household, or
- Needs to share sensitive information that cannot be discussed in the home environment and a transportation barrier exists for an office visit.

All audio-visual and audio-only MIHP telehealth services must be reported with:

- Modifier 93 for audio–only services
- Modifier 95 for audio-visual services
- Report the place of service (POS) code that would be reported as if the beneficiary were in-person for the visit (e.g., home or office)

Inappropriate use of telehealth may include, but is not limited to, circumstances such as when a beneficiary has no barrier for an in-person visit and does not request a telehealth visit.

Telehealth visits that occur via telephone-only are allowable only when a beneficiary barrier exists for use of an audio/visual platform (e.g., lack of smart phone or internet access). Documentation in the beneficiary's chart must include the reason for a telephone-only visit.

MIHP providers are required to follow current Medicaid telemedicine policy requirements as applicable.

2.11 TRANSPORTATION

Transportation services are available to help MIHP-enrolled pregnant and infant beneficiaries access their health care and pregnancy-related appointments and for a mother to visit their hospitalized infant. Pregnancy-related appointments include those for oral health services, WIC services, behavioral or substance use disorder treatment services, and childbirth and parenting education classes. Through the completion of the Risk Identifier, the MIHP provider must assess each MIHP beneficiary's need for transportation services.

Beneficiaries in the Nurse Family Partnership (NFP) do not need a Risk Identifier completed to receive transportation services. Transportation is the only MIHP service available to NFP beneficiaries.

2.11.A. Transportation for MIHP Medicaid Health Plan Enrollees

MHPs are responsible for providing transportation for pregnancy-related appointments for MHP enrolled MIHP and NFP participants. MIHPs are subject to the MHP's internal processes for the coordination of transportation services for MHP enrollees.

2.11.B. Transportation for MIHP Fee For Service Beneficiaries

The MIHP may provide transportation to MIHP Fee-for-Service (FFS) beneficiaries for medical/health care services and pregnancy related appointments when no other means of transportation are available, including transportation from the local MDHHS office. Transportation services provided to the pregnant beneficiary should be billed utilizing the Medicaid ID number of the pregnant woman, and transportation services provided for infant services should be billed utilizing the infant's Medicaid ID number.

Reimbursement for transportation services provided to Medicaid FFS beneficiaries is made according to the allowable amount established by MDHHS and aligns with rates established for Non-Emergency Medical Transportation (NEMT) services. Refer to the MDHHS Non-Emergency Transportation Database located on the MDHHS website. (Refer to the Directory Appendix for website information.)

MDHHS reimburses the MIHP provider an administrative fee equal to six percent of the cost of transportation provided to MIHP FFS beneficiaries. When billing, the six percent fee should be calculated and included in the amount charged, not to exceed the maximum amount allowed. The MIHP provider must determine the most appropriate and cost effective method of transportation. MDHHS reimburses transportation costs at the lesser of actual cost or the maximum/upper limit for:

- Bus
- Mileage (personal, including beneficiary, relative or friend).
- Taxi

  If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDHHS reimburses a maximum of 20 trips per beneficiary through the MIHP.

The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify:

- The name and address of the beneficiary;
- The date of service (DOS);
- The trip's starting point and destination (address, city);
- The purpose of the trip;
- The number of tokens or miles required for the trip;
- The amount that the beneficiary or transportation vendor was reimbursed;

- The provider identification information for the individual or business providing transportation; and
- Verification of transportation provider enrollment in CHAMPS.

The MIHP provider must ensure the beneficiary kept the appointments for which transportation tokens or funds were provided. Medicaid does not pay for transportation not provided.

The MIHP provider may give transportation tokens or funds to the pregnant woman or to the caregiver of the infant. In situations where funds are provided, it is recommended that the pregnant woman or the caregiver sign a receipt and that the receipt be retained in the case records. The MIHP may also contract for transportation services. Transportation services should be billed for each date of service it was provided. MDHHS contracts with a transportation brokerage company to arrange and provide NEMT for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)

2.12 Childbirth Education [Change Made 4/1/2025]

Childbirth education is a series of group classes intended to help:

- Understand the changes in the body during pregnancy;
- Understand the delivery process, including information regarding pre-term labor;
- Understand the postpartum period;
- Care for the infant (classes may include information on developing positive parenting skills);
- Interact with other pregnant women; and
- Build a support network.

First-time mothers must be encouraged to complete the course.

The medical care provider or the MIHP provider may make a referral for childbirth education classes. MIHP providers may provide this service directly or have a contract with a local hospital's outpatient clinic. An outpatient hospital clinic that provides this service may bill Medicaid directly for FFS beneficiaries. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

MIHP childbirth education includes, but is not limited to, the following topics:

- Pregnancy,
- Labor and delivery,
- Infant care and feeding,
- Postpartum care, and
- Family planning.

In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition), childbirth education may be provided in the beneficiary's home as a separately billable service. Case records must document the need for one-on-one childbirth education and where services were provided. (Refer to the Education Reimbursement subsection of this chapter for additional billing information.)

Refer to the Hospital Chapter for additional information regarding coverage requirements for childbirth education. **(text added 4/1/2025)**

2.13 Parenting Education

Parenting education is intended to develop positive parenting skills and attitudes, provide interaction with other parents, and possibly build a support network. Parenting education may be billed once per infant or, in the case of multiple births, once per family.

The infant's medical care provider or the MIHP provider may make a referral for parenting education classes. The services may be provided by the MIHP provider or by contract with an outpatient hospital or community-based organization. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

Parenting education classes should include, but are not limited to,:

- General feeding recommendations throughout the first year of life,
- Normal and abnormal patterns of elimination,
- Common signs and symptoms of infant illness,
- Common childhood injuries and how to care for them,
- Normal range of sleep, rest, activity and crying patterns,
- General hygiene needs of infants,
- Normal developmental milestones of infants throughout the first year,
- Basic emotional needs,
- Basic protection from toxic and/or hazardous waste,
- Basic immunizations and health maintenance, and
- General day-to-day living with children.

(Refer to the Education Reimbursement subsection of this chapter for additional billing information.)

2.14 Lactation Support and Counseling Services

Medicaid will reimburse for evidence-based lactation support services provided to post-partum women in the outpatient setting up to and through 12 months post-delivery when services are provided by a qualified licensed MIHP registered nurse or licensed social worker in possession of a valid and current IBCLC certification. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.

Before initiating MIHP IBCLC services, the initial assessment visit, appropriate Risk Identifier (infant or maternal), and Plan of Care (infant or maternal) must be completed and the Risk Identifier entered into the MIHP database.

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. IBCLC services are considered a component of pregnancy related services. Claims for IBCLC services are to be submitted utilizing the mother's Medicaid beneficiary identification number. Documentation must include the need for maternal lactation support, a begin time and end time of services provided, and a comprehensive description of the professional interventions provided.

For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the MIHP organization in accordance with the record keeping requirements of the Medicaid program.

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information. Refer to the Practitioner Chapter of this manual for additional information related to the service component requirements.

2.15 Transfer of Care/Records

During the course of care, the beneficiary may require services from a different provider due to a move to another area or otherwise request a change of MIHP providers. When an MIHP provider is aware of a planned change in provider, information about the MIHP provider at the new location should be provided to the beneficiary. The referring provider must consult with the new provider about the case and transfer necessary information or records in compliance with the privacy and security requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. A copy of the completed Risk Identifier, POC, and visit notes must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary.

2.16 Immunizations

Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary's (i.e., mother and/or child) immunizations. The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. Before closing an MIHP case, the provider must have assessed immunization status, provided immunization education, and documented accordingly in the case record.

2.17 Special Arrangements for Child Protective Services

Because of the serious nature of MIHP cases, some beneficiaries need the assistance of the MDHHS Children's Protective Services (CPS) program. The MIHP provider must work cooperatively and continuously with the local CPS office. Contact persons for MIHP and CPS must be identified. Referral protocol and a working relationship must be developed and maintained. MIHP is a valuable resource for the CPS program. The MIHP provider must seek CPS assistance in a timely manner. MIHP and CPS work concurrently on at least some referred cases. CPS is not to be viewed as a resource of last resort for the agency to call when all else fails.

The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse/neglect to CPS. When and how the MIHP provider

must refer can best be determined by discussions with the local CPS agency. MIHP activity does not replace the need for required CPS referrals.

2.18 Communications with the Medical Care Provider

When an MIHP case is opened, the MIHP provider must notify the medical care provider within 14 calendar days. When an MIHP case is opened for a pregnant woman with no medical care provider, the MIHP must assist the woman in finding a medical care provider.

The MIHP provider must keep the medical care provider informed of services provided as directed by the medical care provider or when a significant change occurs. The initial assessment visit is the first visit when the Risk Identifier is completed. The communication identifying risks must be sent to the medical care provider within 14 calendar days after the initial assessment visit is completed. The discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and forwarded to the medical care provider when the MIHP case is closed.

2.19 Authorization for Program Exceptions [Changes Made 4/1/2025]

In limited situations, when beneficiary needs surpass outlined MIHP program parameters, the MIHP Operations Team may recommend additional visits for MIHP services, as required, in the following circumstances:

- Initiation of services for a child over 12 months of age;
- Continuation of services beyond 18 months of age (e.g., to assist beneficiaries facing end-of-life concerns (mother or infant) or in cases where an alternative program is unfeasible);
- Professional observation indicating that a beneficiary will benefit from MIHP services after being assessed with no risks using the appropriate program assessment tool (Risk Identifier); and
- Maternal professional visit during a NICU stay following the mother's discharge from labor and delivery stay. **(text revised/added 4/1/2025)**

MIHP providers seeking program exceptions for all beneficiaries must submit documentation to the MIHP Operations Team that supports any identified risks and how the beneficiary may benefit from services. As a reminder, program screening tools and educational materials utilized by the MIHP are designed for maternal and infant use only.

The MIHP Operations Team will be responsible for direct authorization of program exceptions for FFS beneficiaries. For beneficiaries enrolled in MHPs, the MIHP Operations Team will recommend exception visits to the MHPs. MHPs will be responsible for the review and processing of the prior authorization request for the services in accordance with their utilization management processes. All approved written authorizations are to be kept in the beneficiary's MIHP provider file and must be available upon request. Additionally, as applicable, the MIHP provider is required to note any granted authorizations in the program approved communication tool for a beneficiary enrolled in a Medicaid Health Plan.

SECTION 3 – REIMBURSEMENT

To receive reimbursement for services, the MIHP billing National Provider Identifier (NPI) must be a facility, agency, or organization. A MIHP specialty must be indicated when enrolling as a MIHP provider through CHAMPS. Claims should include a primary diagnosis code for an infant-related or pregnancy-related condition. Providers are encouraged to report a secondary diagnosis reflecting a social determinant of health (SDOH) utilizing the ICD-10 codes in the category range Z55-X65. The MIHP provider must bill only the procedure codes listed in the MDHHS Maternal Infant Health Program Database located on the MDHHS website. (Refer to the Directory Appendix for website information.)

All services provided by MIHP providers to MHP enrollees should be billed directly to the MHP. All services provided by MIHP providers to Fee-for-Service beneficiaries should be billed directly to MDHHS. MIHP services are a Medicaid only benefit. MIHP providers are not required to secure other insurance adjudication response(s) for claims for MIHP services prior to billing Medicaid FFS or MHPs, as the parameters of other carriers would never cover MIHP services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.)

The Risk Identifier is required to be completed and entered into the MIHP database before the service is billed. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) MIHP providers receive separate reimbursement for each Risk Identifier form completed and entered into the MIHP database even if it is determined the beneficiary does not need MIHP services. The Risk Identifier is billed and reimbursed based on place of service. As with all Medicaid services, documentation must support the services billed and paid.

Reimbursement is limited to one Maternal Risk Identifier per pregnant woman during their pregnancy and one Infant Risk Identifier per infant. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, an MIHP provider may do a Risk Identifier on a pregnant woman and receive reimbursement twice in the same year. In such instances, the provider must indicate "second pregnancy" in the remarks section of the claim when billing for the service.

Reimbursement for a professional visit is based on the place of service. The place of service must be documented in each professional visit note and billed accordingly. Medicaid reimbursement for a professional visit includes related care coordination and monitoring of activities.

Services scheduled but not provided to the beneficiary are not billable. This includes all MIHP services. The beneficiary must not be billed for visits provided beyond the established limit.

3.1 EDUCATION REIMBURSEMENT

Reimbursement for MIHP childbirth education classes and/or parenting education classes are for the complete course, regardless of the number of classes needed to complete the course. At a minimum, the course outline found in the Maternal Infant Health Program Operations Guide must be covered. Additional items may be added at the discretion of the provider. The pregnant woman or caregiver must attend at least one-half of the classes or cover at least one-half of the curriculum for the service to be billed. Dates of attendance must be documented in the beneficiary's record. If the class is offered in the community, but not all items on the outline are covered, the missed items should be covered during a professional visit and not billed separately as education.

- MIHP childbirth education may be billed one time per beneficiary per pregnancy.

- MIHP parenting education may be billed one time per infant. In the case of twins or other multiple births, parenting education may be billed only once for the family.

If the MIHP provider refers the beneficiary to a local hospital to provide the classes, the hospital must bill the appropriate MHP to receive payment. If the MIHP provider contracts with an outpatient hospital or community based organization for childbirth education, the contract must indicate which provider is to bill and receive payment. If the classes are available at no charge to the public from a community-based organization, the MIHP cannot bill the Medicaid Fee-for-Service program or the beneficiary for the service.

SECTION 4 - FORMS

MIHP providers must use standardized forms developed by MDHHS. Copies of the forms are located in the Maternal Infant Health Program Operations Guide and/or on the MDHHS website. (Refer to the Directory Appendix for website information.) At a minimum, the data elements included in these forms must be maintained. If additional data elements are needed, it is suggested the agency develop a separate form to accommodate their needs, to be used in addition to the state forms. The goal is to have standardized forms statewide.

SECTION 5 - OPERATIONS AND CERTIFICATION

MDHHS certifies MIHP providers. To become an MIHP provider, the criteria in the Michigan Medicaid Provider Manual and the Maternal Infant Health Program Operations Guide must be met. Provider participation criteria includes, but is not limited to, required staffing and the capacity to provide services, including outreach, and weekend and after-hours coverage. MIHP providers must follow all policies and procedures in the Michigan Medicaid Provider Manual in addition to the Maternal Infant Health Program Operations Guide.

5.1 CRITERIA

Providers must meet the following participation criteria.

- The provider must meet program requirements to qualify for enrollment in Medicaid.
- In cases where services are provided through a contract with another agency, the contract or letter of agreement must be on file for review by MDHHS. It must specify the time period of the agreement, the names of the individuals providing services, and where the billing responsibility lies.
- The provider's physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements.
- The provider must have experience in the delivery of services to the target population and demonstrate understanding of the concept and delivery of maternal and infant services.
- The provider must demonstrate linkages to relevant services and health care organizations in the area to be served.
- The organization must demonstrate a capacity to conduct outreach activities to the target population and to medical providers in the geographic area to be served.

5.2 STAFFING

Required staff for the MIHP is comprised of licensed registered nurses and licensed social workers. Optional staff may include a registered dietitian, infant mental health specialist, or an IBCLC. All staff must meet the qualifications as stated in the Staff Credentials subsection of this chapter.

5.3 OPERATIONS AND CERTIFICATION REQUIREMENTS

Providers must demonstrate their ability to validate the need for, and delivery of, MIHP services appropriate to each beneficiary's individual need. The MIHP must:

- Deliver services appropriate to the beneficiary's level of understanding.
- Schedule services to accommodate the beneficiary's situation.
- Complete appropriate Risk Identifier by a licensed social worker or a registered nurse.
- Develop the plan of care by a licensed social worker and a registered nurse (jointly).
- Complete the Risk Identifier based on a home visit as required for the infant and, if possible, for the pregnant woman.

- Demonstrate a system for handling beneficiary grievances.
- Provide for weekend and after-hours emergencies.
- Provide directly or arrange for bilingual services, and services for the visually impaired and/or hearing impaired, as indicated.
- Maintain all physician orders in the medical record.
- Coordinate agency and community services for the beneficiary.
- Arrange transportation services when appropriate.
- Respond to referrals promptly to identify the beneficiary's needs (within a maximum of 7 calendar days for the infant and 14 calendar days for the pregnant woman).
- Respond to referrals received prior to the infant's discharge from the inpatient setting within two business days of hospital discharge.
- Notify the medical care provider of the beneficiary's enrollment within 14 days.
- Document and report disposition of the referral (i.e., initiation of services, inability to locate, or refusal of services) to the referring source.
- Provide ongoing communication with the beneficiary's medical care provider.
- Provide, directly, the services of at least a registered nurse or licensed social worker. Infant mental health specialist and/or registered dietitian services may be provided through a subcontractor or services may be accessed in other ways.
- Not bill for services provided by community resources.
- Provide services in a clinic, an office, a home setting and/or community setting, as appropriate.
- Maintain a current list of local Public Health programs such as WIC Nutrition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Community Mental Health (CMH), Children's Special Health Care Services (CSHCS), and other agencies that may have appropriate services to offer the beneficiary, and agree to work cooperatively with these agencies.
- Have written protocols that comply with the reporting requirements mandated by the Michigan Child Protection Law (Act No. 238, Public Acts of 1975). Include protocols on coordination with the CPS unit of the local MDHHS office that specify how the MIHP provider will make CPS referrals, initiate follow-up contacts with CPS, and participate in local CPS multidisciplinary team meetings involving infants served by the MIHP.
- Maintain an adequate and confidential beneficiary records system, including services provided under a subcontractor. (HIPAA standards must be met.)
- Have written internal protocols to include all aspects of the program.
- Be actively linked to or a member of the Great Start Collaborative. When providing infant services, in addition to the Great Start Collaborative, providers must also be actively linked to or be a member of the local Part C/Early On Interagency Coordinating Council.
- Report all new MHP enrollees to the appropriate MHP on a monthly basis or as agreed to in the Care Coordination Agreement.
- Follow all procedures as written in the Maternal Infant Health Program Operations Guide.

- Follow all Medicaid policies as published in the MDHHS Medicaid Provider Manual, Behavioral and Physical Health and Aging Services Administration (BPHASA) Bulletins, and the Maternal Infant Health Program Operations Guide.

5.4 Issuance of Certification

Based upon satisfactory application, MDHHS provides a provisional MIHP certification. After an agency is provisionally certified and providing services, MDHHS conducts a provider site visit. The site visit must occur within six months of the provisional certification. The site visit is to observe how the program is being implemented and to assist in resolving any problems experienced in the implementation of the program. Based upon the site visit, MDHHS grants the agency either a six-month certification, a three-year certification, or discontinues certification. MDHHS makes a formal certification visit every three years, with informal site visits at more frequent intervals.

If at any time after receiving certification the provider becomes deficient in any of the qualifying criteria, including staffing, the provider must notify the MDHHS Division of Family & Community Health immediately. (Refer to the Directory Appendix for contact information.) MDHHS then determines whether the agency may continue providing services given the deficiency(ies). The MDHHS decision is based on the evaluation of many factors, including the number of deficiencies, the specific deficiency(ies) involved, the availability of other providers in the area, impact on caseload, etc.

If at any time the MIHP provider fails to meet the program policies or certification requirements, Medicaid reimbursement can be jeopardized. The MIHP provider is subject to audit by Medicaid and if any discrepancy(ies) is found, appropriate follow-up action may be taken, such as recoupment of payments, holding reimbursement on claims, or termination of Medicaid enrollment. If a negative action is imposed, the MIHP provider is given an opportunity for appeal.

Agencies wishing to become a MIHP provider may contact the MDHHS Division of Family & Community Health. (Refer to the Directory Appendix for contact information.)

MATERNITY OUTPATIENT MEDICAL SERVICES PROGRAM

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SECTION 1 – GENERAL

The Maternity Outpatient Medical Services (MOMS) program covers outpatient pregnancy-related services for the unborn child of an undocumented pregnant woman during the prenatal and postpartum period as well as inpatient delivery-related services. MOMS will also cover family planning services for the mother during the postpartum period.

1.1 ELIGIBILITY DETERMINATION

Women who are pregnant and meet the following criteria may apply for MOMS coverage:

- Income at or below 195 percent of the Federal Poverty Level.
- Covered by the Medicaid Emergency Services Only (ESO) program.

Women who are incarcerated in any institution where residents are precluded from using their Medicaid coverage are not eligible for this program.

1.2 PERIOD OF COVERAGE

The MOMS enrollment period is from the date of application, once eligibility is determined, through 60 days after the pregnancy ends. The maximum period of retroactive eligibility for MOMS is 90 days from date of application.

1.3 VERIFYING ELIGIBILITY

MOMS beneficiaries are identified in the eligibility response with the Benefit Plan ID of MOMS. (Refer to the Beneficiary Eligibility chapter for additional information.) When a woman is determined eligible for the MOMS program via the presumptive eligibility process, a presumptive eligibility decision notice is shared. This notice includes the MOMS coverage dates.

SECTION 2 – SERVICES

2.1 COVERED SERVICES

The following services are covered consistent with current MOMS policy:

- Prenatal period services, including:
  - Prenatal care and pregnancy-related care
  - Condoms (covered in the prenatal period for sexually transmitted infection [STI] prevention)
  - Pharmaceuticals and prescription vitamins
  - Laboratory services
  - Radiology and ultrasound
  - Maternal Infant Health Program (MIHP) - for prenatal services only
  - Childbirth education
  - Outpatient hospital care
  - ACIP recommended vaccines and their administration
- Labor and delivery services (including all professional and inpatient hospital services) are covered.
- Postpartum care is limited to medically necessary ambulatory postpartum services.
- Doula services through 60 days postpartum.
- Family planning services, including:
  - Office visits for family planning related services, including preventive evaluation and management office visits and other outpatient visits for family planning services.
  - Contraceptives, including oral contraceptives and injectables.
  - Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy.
  - Diagnostic evaluation and pharmaceuticals related to contraceptive management or the initial treatment of sexually transmitted infections.
  - Sterilizations completed in accordance with current Medicaid policy.
  - Counseling for family planning services, including sterilization, as a part of the family planning visit.
- Behavioral health and substance use disorder (SUD) services and supports are covered during the prenatal period and through 60 days postpartum. Covered services include, but are not limited to:
  - Appropriate screenings and preventive services
  - Behavioral health treatment services and validated clinical assessment tools

- Perinatal depression screening, counseling, and intervention
- Medication-Assisted Treatment (MAT) for SUD
- Tobacco use interventions for smoking cessation
- Inpatient, outpatient, and residential treatment
- Emergency services, crisis intervention and stabilization
- Behavioral health and SUD-related case management services

- Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for information on coverage details of the specialty supports and services provided through the local Prepaid Inpatient Health Plans (PIHPs). For services not included in the capitation payments to the PIHPs, services are covered through Medicaid Fee For Service.

2.2 Noncovered Services [Change Made 7/1/2025]

The following services are not covered under the MOMS benefit:

- Postpartum outpatient lactation support and counseling services provided by an IBCLC
- Postpartum MIHP coverage
- Dental services **(revised 7/1/2025)**

2.3 Prior Authorization

If a service does not meet the definition of the pregnancy-related services noted above or if the service normally requires prior authorization (PA) by the Medicaid program, a PA request must be submitted to MDHHS. Requests of authorization of pharmaceuticals must be made to the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

SECTION 3 – BILLING & REIMBURSEMENT

Billing and coordination of benefits policies and procedures, as well as reimbursement rates, parallel Medicaid. (Refer to the Billing & Reimbursement and the Coordination of Benefits Chapters of this manual for additional information.)

3.1 SUBMITTING MEDICAL CLAIMS

MOMS claims should be held until the beneficiary's eligibility can be verified using:

- CHAMPS Eligibility Inquiry
- HIPAA 270/271 (Eligibility Inquiry/Response) transactions
- Web-based options

(Refer to the Beneficiary Eligibility Chapter for additional information.)

Providers must use the appropriate Z30 International Classification of Diseases (ICD) diagnosis code as the primary diagnosis on claims for family planning services.

3.2 SUBMITTING PHARMACY CLAIMS

Pharmacy services provided to MOMS beneficiaries must be billed to the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

Family planning supplies not furnished by the practitioner as part of the medical services must be prescribed by a Medicaid enrolled practitioner and dispensed by a pharmacy. Exceptions include condoms and similar supplies that do not require a prescription.

MEDICAID HEALTH PLANS (MHPS)

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Technology, Management & Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of this manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Breast pumps; personal use, double-electric
- Certified Clinical Nurse Specialist services
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- Community Health Worker (CHW)/Community Health Representative (CHR) services
- Dental services for adults
- Diagnostic lab, x-ray and other imaging services
- Doula services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education

- Hearing and speech services
- Hearing aids
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility) for up to 45 days
- Long-term care acute hospital services (LTACH)
- Maternal Infant Health Program (MIHP)
- Medically necessary weight reduction services
- Mental health care
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral-maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for all medically necessary Medicaid covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

The covered services provided to Healthy Michigan Plan enrollees under the contract include all those listed above and the following additional services:

- Additional preventive services required under the Patient Protection and Affordable Care Act as outlined by MDHHS

1.2 Services Excluded from MHP Coverage but Covered by Medicaid

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- MDHHS also maintains a list of specific Medicaid program-covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP. (Refer to the Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans subsection of the Practitioner chapter of this manual for additional information. Refer to the Directory Appendix for website information for the physician-administered drugs and biological products list.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services
- Private Duty Nursing services
- Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
  - Screening and assessment;
  - Detoxification;
  - Intensive outpatient counseling and other outpatient services; and
  - Methadone treatment
- Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program.
- Services provided to an individual with Medicaid who resides in a State Veterans' Home
- Pediatric Outpatient Intensive Feeding Program services

1.3 Services that MHPs are Prohibited from Covering

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment;
- Elective cosmetic surgery; and
- Services for treatment of infertility.

SECTION 2 - SPECIAL COVERAGE PROVISIONS

This section provides general information regarding MHP coverage requirements for certain services. Additional information regarding the MHP requirements related to these services is contained in the MHP contract. A copy of the contract is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.1 COMMUNICABLE DISEASE SERVICES

MHPs must allow enrollees to receive treatment services for communicable diseases from local health departments without prior authorization. For purposes of this section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

2.2 DENTAL SERVICES

Adult beneficiaries enrolled in a health plan will receive their dental coverage through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed. For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers through the Medicaid FFS program. For dental program coverage policy, refer to the Dental Chapter of this manual. The Dental Chapter also contains information on the Healthy Kids Dental benefit, as applicable.

2.3 EMERGENCY SERVICES

MHPs are responsible for emergency services, including the medical screening exams, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)) and the Federal Balanced Budget Act of 1997. MHPs may not require prior authorization for emergency screening and stabilization services provided to enrollees.

MHPs are not responsible for paying for non-emergency treatment services beyond screening that are not authorized by the MHP. Coverage for emergency services includes emergency transportation, hospital emergency room services, and professional services.

2.4 FAMILY PLANNING SERVICES

MHP enrollees have full freedom of choice of family planning providers, both in-plan and out-of-plan. MHPs may not require prior authorization for family planning services, including the detection and treatment of STDs. MHPs may advise out-of-network family planning providers, including public providers, to communicate with primary care providers (PCPs) once any form of medical treatment is undertaken.

2.5 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

MHP enrollees may access services provided through a Federally Qualified Health Center (FQHC).

FQHC providers must obtain prior authorization from the MHP. However, the MHP may not refuse to authorize medically necessary services if the MHP does not have a FQHC in the network in the county. The MHP may require FQHC providers to share information and data with the MHP and to provide appropriate referrals to providers in the MHP's network.

2.6 Maternal Infant Health Program (MIHP)

Effective for dates of service on or after January 1, 2017, MIHP services provided to individuals enrolled in an MHP are administered by the MHP as outlined in the Maternal Infant Health Program Chapter of this manual. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs. Only MDHHS certified providers may deliver MIHP services to MHP enrollees.

To maintain fidelity of the program and to facilitate compliance with the reporting requirements of Public Act 291 of 2012, it is the expectation that MIHP providers and MHPs will adhere to program components, including but not limited to: MDHHS program certification, the required professional qualifications of staff, and the use of MDHHS MIHP forms. MHPs must establish and maintain a Care Coordination Agreement (CCA) with MIHP providers for both in-network and out-of-network services.

Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services.

MHPs work cooperatively with the local MDHHS office to maintain a referral protocol for those enrollees who need the assistance of MDHHS Children's Protective Services. MIHP providers must work with the MHP and MDHHS Children's Protective Services to ensure appropriate care for MHP enrollees. (Refer to the Maternal Infant Health Program Chapter of this manual for additional information.)

2.7 Out-of-Network Services

2.7.A. Professional Services

With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services;
- Tuberculosis services; and
- Certain MIHP services (refer to the Maternal Infant Health Program Chapter for additional information).

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service.

2.7.B. Hospital Services

MHPs reimburse hospitals according to the terms of the contract between the MHP and the hospital. If a hospital does not have a contract with an MHP but has signed a hospital access agreement with MDHHS, the following conditions apply:

- The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid beneficiaries enrolled in MHPs with which the hospital does not have a contract.
- MHPs agree to continue to use network-contracted providers when available and appropriate.
- The hospital will be entitled to payment by MHPs for all covered and authorized (if required) services provided in accordance with their obligations under the agreement.
- A rapid dispute resolution process will be available for hospitals and MHPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- MHPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. The payment for inpatient stays includes the relevant DRG and capital costs.

Copies of the Hospital Access Agreement, Health Plan Obligations, and Rapid Dispute Resolution are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Hospitals that have signed the Hospital Access Agreement and the MHPs are required to abide by the terms and conditions of the Agreement.

2.7.C. Post-Stabilization Authorization Determinations

Non-contracted hospitals are required to obtain a patient post-stabilization authorization determination from the beneficiary's MHP prior to any treatment and after stabilization. A post-stabilization authorization determination refers to the process in which inpatient hospital admission or admission to observation status is authorized by the MHP after the beneficiary has been stabilized. (Note: This applies only to MHP beneficiaries who are not dually Medicare and Medicaid eligible. MHPs may not utilize prior authorization (PA) requirements for hospital services for dual Medicare and Medicaid eligible beneficiaries enrolled in an MHP and Medicare fee-for-service.)

Hospitals are required to make and document all post-stabilization authorization requests by telephone call to the beneficiary's MHP prior to providing any treatment after stabilization. Hospitals must provide the MHP with all requested, necessary and current information, including the clinical status upon initial presentation, the clinical status after stabilization, and the initial treatment plan. This information must be provided in accordance with the Emergency Medical Treatment & Active Labor Act (EMTALA). The MHP is required to respond to post-stabilization requests within one hour of receipt of the telephone call and may not require hospitals to make additional phone calls if the initial phone call included all necessary and current clinical information. If the MHP does not respond within one hour, authorization for inpatient admission, payment and additional services is automatic.

Within one hour of the phone call in which the hospital provides the required clinical information noted above, the MHP must make an authorization decision which specifies the service authorized. The decision must be based on the information presented by the hospital at the time of the request rather than a list of pre-determined diagnoses that automatically authorize the patient for admission to observation status and not admission to the inpatient hospital. The MHP may not indicate that observation or admission will be authorized depending upon the clinical outcomes, and the MHP may not subsequently reverse an authorization decision based upon the clinical outcomes or length of time the patient remains in inpatient status. If the hospital and MHP are unable to reach agreement on an authorization decision at the time of the request, the hospital and the MHP must arrange a discussion between physicians in order to resolve the dispute.

The MHP contract requires MHPs to provide twenty-four (24) hour, seven (7) days-a-week availability for post-stabilization authorization requests. Hospitals may not wait until the next business day after stabilization to call for authorization. If the hospital does not call for authorization after stabilization prior to providing additional services, the MHP may review the clinical record at the time of request for authorization or payment to determine if inpatient hospital admission or admission to observation status was clinically appropriate.

2.8 Mental Health

MHPs are required to provide behavioral health services not included under the Prepaid Inpatient Health Plan (PIHP) specialty services and supports benefit. The Non-Physician Behavioral Health Appendix of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies and procedures related to these outpatient behavioral health services. Services should be provided through appropriate providers within the service area and may include contracted Community Mental Health Service Program (CMHSP) providers.

For specialty behavioral health needs, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided to the beneficiary. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.

2.9 Child and Adolescent Health Centers and Programs (CAHCP)

2.9.A. Requirements

MHPs must allow enrollees to obtain services from a CAHCP without prior authorization from the MHP. In order to receive payment for covered services, CAHCPs must follow the MHP's billing policies and procedures.

If the CAHCP is in the MHP's provider network, the following conditions apply:

- Covered services must be administered or arranged by a designated primary care physician (PCP).
- The CAHCP must meet the MHP's written credentialing and re-credentialing policies and procedures.

- The CAHCP must meet the MHP's criteria for ensuring quality of care and ensuring that all providers are licensed by the State of Michigan and practice within their scope of practice as defined in Michigan's Public Health Code.

2.9.B. Outreach Services

MHPs contract with CAHCPs to provide outreach services to school-aged children on behalf of the respective plans. The following represent categories of outreach activities that CAHCPs must provide under the contracts:

- Medicaid outreach and public awareness
- Facilitating Medicaid eligibility determination
- Program planning, policy development, and interagency coordination related to Medicaid services
- Referral, coordination, and monitoring of Medicaid services
- Medicaid-specific training on outreach eligibility and services

2.10 Substance Abuse, Inpatient and Outpatient

MHPs are not responsible for either inpatient or outpatient substance abuse services. Acute medical detoxification services for Medicaid beneficiaries are reimbursed directly by MDHHS. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this manual for information on substance abuse services provided through PIHPs/CMHSPs.)

2.10.A. Inpatient

FFS covers an inpatient hospitalization designed for the purpose of detoxification in an inpatient setting. The primary diagnosis on the claim must document that the hospitalization was for the sole purpose of providing an inpatient setting for detoxification. Inpatient detoxification is only allowed under Medicaid policy under limited conditions described in the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of this manual.

MHPs cover inpatient hospitalization if the beneficiary is hospitalized for medical complications due to substance abuse. In these cases, the primary diagnosis will reflect the medical problem for which the beneficiary was admitted; substance abuse may be a secondary diagnosis. The existence of substance abuse as a secondary diagnosis does not render the admission payable by FFS under the inpatient acute detoxification exception; the MHP is responsible for the claim.

2.10.B. Emergency Services

If the beneficiary is subsequently admitted to an inpatient facility, the emergency services are covered as part of the DRG payment.

If the beneficiary is not admitted, payment for screening and stabilization is covered by the MHP. Hospitals must comply with authorization requirements for services beyond screening and stabilization.

If the beneficiary is not admitted and the services provided in the emergency room (beyond screening and stabilization) are for the sole purpose of treating the substance abuse, e.g., conducting an intake interview for substance abuse treatment, the regional PIHP is responsible for those services. The PIHP is not responsible for the screening and stabilization or other medical treatment provided in the emergency room even if a beneficiary's substance abuse is the underlying cause of the medical problem.

2.10.C. Co-Occurring Mental Health and Substance Use Disorders

For beneficiaries eligible for mental health services under the MHP contract, MHPs may not deny mental health treatment due to the existence of a co-occurring substance use disorder. MHPs must provide the medically necessary mental health services whether the substance abuse diagnosis is the beneficiary's primary diagnosis or a secondary diagnosis.

While MHPs are not required to provide substance abuse treatment, the MHP should direct the plan's mental health providers to identify potential substance abuse issues. If a substance abuse issue is identified, the MHP must provide the medically necessary mental health treatment and coordinate with the appropriate Pre-Paid Inpatient Health Plan (PIHP) regarding the member's substance abuse treatment. MHPs must provide medically necessary mental health services without consideration of the member's decision to seek, or not seek, substance abuse services or on the success or failure of substance abuse treatment.

MHPs must educate providers regarding screening and referral for substance abuse issues. A document that lists the MHP and PIHP available in each county to facilitate coordination among the PIHP and MHP, as well as a listing of available telephone numbers, is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.11 Tuberculosis Services

MHP enrollees may obtain testing for tuberculosis from Local Health Departments (LHDs) without MHP prior authorization. Treatment may also be provided by the LHD without prior MHP authorization and regardless of whether a contractual or coordinating relationship exists between the MHP and the LHD. In the absence of a contract or other coordinating agreement, MHPs will reimburse the LHD at Medicaid fee-for-service (FFS) rates in effect on the date of service.

2.12 Hospital 15-Day Readmissions

MDHHS developed a set of readmission guidelines for hospitals and Medicaid Health Plans to utilize in determining whether a 15-day readmission should be treated as a separate admission or a combined admission for payment purposes. The guidelines and suggested discharge documentation elements provide clarification of the policy specified in this manual. The guidelines do not replace or revise the 15-day readmission policy detailed in the Hospital Chapter.

Accurate and complete documentation and discharge planning is vital to successfully implementing the readmission grid which enables the hospital and MHP to agree on whether a readmission should be separate or combined for payment purposes. The guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Hospitals and MHPs are encouraged to work together to develop discharge documentation and planning processes that are mutually agreeable. If a hospital system utilizes discharge documentation and planning processes that provide all necessary information, MHPs should not require the hospital system to replace the existing processes with a specific documentation template developed by the MHP.

Alternatively, if a hospital system's discharge documentation and planning processes do not provide all necessary information, the hospital system should revise their existing documentation processes to include the necessary information. If the hospital system does not have a discharge documentation and planning process, the MHP and hospital should work together to develop mutually agreeable documentation processes.

SECTION 3 – CLAIMS, COPAYMENTS AND REIMBURSEMENT

MHP claim completion requirements must be consistent with MDHHS claim completion requirements as detailed in the Billing and Reimbursement chapters of this manual.

3.1 BLOOD LEAD TESTING

MHPs are encouraged to establish contractual or other coordinating relationships with local health departments (LHDs) that provide blood lead testing services. LHDs must conduct blood lead testing consistent with Medicaid policy. Similarly, MHPs must reimburse LHDs for blood lead testing as directed by Medicaid policy.

3.2 COPAYMENTS

Beneficiaries enrolled in an MHP may have different copayment requirements through the MHP than through FFS. The MHP copayment amount must be less than or equal to the Medicaid FFS copayment amount for the same service. Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. A list of current copayments is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.3 PAYMENT RESPONSIBILITY WHEN ENROLLMENT STATUS CHANGES

MHPs should refer providers to the Billing and Reimbursement chapters of this manual for clarification of payment responsibility if a Medicaid or CSHCS beneficiary changes enrollment status during a course of treatment.

3.4 REIMBURSEMENT FOR NONCONTRACTED PROVIDERS

Reimbursement for providers who are contracted with the MHP is governed by the terms of the contract. MHPs are required to pay noncontracted providers at Medicaid FFS rates for all properly authorized, medically necessary services for which a clean claim is submitted. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements.

SECTION 4 - MEDICAID HEALTH PLAN RATES

4.1 GENERAL INFORMATION

Federal regulations (42 CFR 438.6) require rates paid by the State of Michigan to MHPs to be actuarially sound. The State of Michigan contracts with a certified actuary to develop actuarially sound rates for the MHPs. Rates are not included in the MHPs competitive bid process and, therefore, the MHPs are not required to certify rates as actuarially sound. Under this methodology, the State's Actuary establishes a rate range for each rate cell covered under the Comprehensive Health Care Program. As mandated by the federal requirement, the State's Actuary certifies these rates are actuarially sound. There is no federal requirement that rates be actuarially sound for a particular MHP.

Actuarially sound rates for MHPs are capitation rates that meet the following requirements:

- Developed in accordance with generally accepted actuarial principles and practices.
- Appropriate for the populations included and services covered under the State's contract with the MHPs.
- Certified as meeting all requirements for actuarial soundness by actuaries who meet the qualification standards established by the American Academy of Actuaries and who follow the practice standards established by the Actuarial Standards Board.

4.2 RATE CATEGORIES

In order to establish actuarially sound rates, MDHHS establishes separate rate cells based on the following classifications:

- Aid program category
- Age
- Gender
- Region
- Maternity case rate

For enrollees in the Blind and Disabled program category, Michigan utilizes the Chronic Illness and Disability Payment System (CDPS) to adjust the MHP capitation rates. Under CDPS, diagnosis coding (as reported on claim and encounter transactions) is used to compute a score for each individual. Individuals with inadequate eligibility history are excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case-mix value for each contractor based on its enrolled population. The regional rate for the Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each MHP. The aggregate impact is budget or rate neutral. MDHHS fully re-bases the risk adjustment system annually.

4.3 Data Methodology

MDHHS has a generally consistent approach to the rate development and certification methodology. The approach incorporates the factors recommended by the American Academy of Actuaries, including the following criteria:

- Base utilization and cost data are derived from the population covered under the MHP contract to the extent that adequate accurate information on this population is available to the State's Actuary at the time of rate development and certification.
- Base utilization and cost data are derived from the population comparable to the population covered under the MHP contract.
- Base utilization and cost data are derived from the set of covered services under the MHP contract.
- Adjustments may be made to smooth data and account for factors such as incomplete data.
- Assumptions may be made related to medical trend inflation, MHP administration, and projected utilization.
- Rate cells are specific to the enrolled population.
- Assumptions may be made related to payment mechanism, utilization, and cost appropriate for individuals with chronic illness, disability, risk adjustment or other appropriate cost-neutral methods.
- Assumptions are based on the State Actuary's professional judgment regarding the appropriateness of adjustments to the base year data.

4.4 Data Sources

The annual rate development methodology for the establishment of actuarially sound rates utilizes some or all of the following data sources:

- Fee for service (FFS) data for individuals eligible for Medicaid.
- FFS data for the 12 months preceding the individual's enrollment into the MHP.
- Aggregate MHP financial and/or encounter data.
- MHP annual financial filings reported to the Department of Insurance and Financial Services (DIFS) up to 36 months preceding the date that the proposed rates were established by MDHHS.
- Other data available to MDHHS that is for the covered population and which is identified in the report produced by MDHHS.

MDHHS utilizes the data source deemed most appropriate by the State's Actuary dependent upon data availability and data accuracy.

4.5 Public Review of Data Methodology

MDHHS shall produce for public review a report that includes the proposed MHP rates, documentation of the rate development, and actuarial certification prior to formal submission to the federal government. As recommended by the American Academy of Actuaries, the report shall include a description of the relevant data, sources of data, material assumptions, and methodology by which the rates were developed.

SECTION 5 – MEDICAID HEALTH PLAN PROVIDER ENROLLMENT

MHPs are prohibited from making payments to all typical network and out-of-network Michigan providers who appear on a claim and are not enrolled in CHAMPS. Typical providers are professional health care providers who provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.)

MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid beneficiaries with emergency medical services. Payment for out-of-state, out-of-network medical services are subject to Medicaid policy and applicable health policies and procedures. (Refer to the Out-of-Network Services subsection of this chapter for additional information.)

Refer to the General Information for Providers Chapter, Provider Enrollment section of this manual for additional provider enrollment information.

MEDICAL SUPPLIER

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SECTION 1 – PROGRAM OVERVIEW [CHANGE MADE 4/1/2025]

This chapter applies to Medical Suppliers/Durable Medical Equipment and Orthotists/Prosthetists.

The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.

This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and Michigan Department of Health and Human Services (MDHHS) includes both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics.

Below are common terms used throughout this chapter:

Medical Supplies	Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any **non-institutional*** setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary. Medical supplies are items covered that: ▪ Treat a medical condition. ▪ Prevent unnecessary hospitalization or institutionalization. ▪ Support Durable Medical Equipment (DME) used by the beneficiary.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any **non-institutional*** setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of illness, injury or disability. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when: ▪ It is medically and functionally necessary to meet the needs of the beneficiary. ▪ It may prevent frequent hospitalization or institutionalization. ▪ It is life sustaining.
Complex Rehabilitation Technology (CRT) Equipment	CRT equipment is a subcategory of DME that can be individually configured to meet the medical/functional needs of beneficiaries with complex physical or functional limitations (e.g., traumatic brain injury, amyotrophic lateral sclerosis, spina bifida, etc.). CRT equipment includes specialized manual and power wheelchairs with additional options/accessories, adaptive seating and positioning, standing frames, gait trainers. Individually configured means the equipment has various sizes, features, and modifications that a qualified CRT provider can apply specific to the beneficiary by measuring, fitting, programming, adjusting or adapting the equipment consistent with the beneficiary's medical/functional needs as identified by the evaluation of a qualified health care professional (QHCP). **(text added per bulletin MMP 24-58)**

Mobility Related Activities of Daily Living (MRADL)	Daily activities (e.g., grooming, dressing, toileting, etc.) the beneficiary is able to perform with the aid of mobility equipment.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Prevent or reduce contractures. ▪ Facilitate healing or prevent further injury.
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ▪ Improve and/or restore the beneficiary's functional level. ▪ Enable a beneficiary to ambulate or transfer.

*MDHHS considers an institution to be a nursing facility, hospital or intermediate care facility for individuals with intellectual disabilities.

Durable medical equipment, medical supplies and orthotics must be registered with the Food and Drug Administration, except for custom-fabricated items. (Refer to the Standard Equipment and Custom-Fabricated Seating and the Noncustom versus Custom-Fabricated subsections for additional information.)

1.1 PROVIDER TYPES [CHANGE MADE 4/1/2025]

Services provided must be appropriate for the specified provider types according to the CHAMPS Provider Enrollment (PE) on-line application. The provider types and the services they may provide are as follows:

Orthotist and Prosthetist	▪ Prefabricated, custom-fitted and custom-fabricated orthoses and prostheses ▪ Medical supplies related to orthotics and prosthetics (e.g., stump socks, etc.) ▪ Shoes
Medical Supplier	▪ Durable medical equipment (including oxygen) Medical supplies ▪ Prefabricated and specific custom-fitted orthoses (custom-fitting may only include simple or minor intervention) ▪ Shoes
Complex Rehabilitation Technology (CRT) Supplier	Medical Supplier with a CRT subspecialty that supplies CRT and accessories. Examples: ▪ Specialized manual and power wheelchairs ▪ Gait trainers ▪ Standing systems/frames ▪ Adaptive seating and positioning equipment **(text added per bulletin MMP 24-58)**
Shoe Store	▪ Shoes, selected shoe inserts and additions

1.1.A. Provider Enrollment

Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem. (Refer to the General Information for Providers chapter for provider enrollment policy that applies to all providers.)

To be eligible to enroll as a Medicaid DMEPOS provider, applicants must be compliant with policy indicated in the General Information for Providers chapter and all of the following:

- The provider must be compliant with all federal and state licensing, certification and regulatory requirements.
- The provider must have a national provider identifier (NPI) for each location and may not allow another entity to use that billing NPI (separate enrollment is required for each location serving Medicaid beneficiaries).
- The provider must be accredited (separate accreditation per location) by one of the Centers for Medicare & Medicaid Services (CMS) approved accreditation organizations (AOs) and must indicate the specific DMEPOS items approved under that accreditation for that location (CMS-determined pharmaceutical exemptions apply).
- The provider must permit MDHHS to conduct on-site inspections to evaluate the provider's compliance with State and Federal DMEPOS standards.
- The provider must have a primary business telephone listed under the business name in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during business hours is prohibited.
- The provider must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. The provider may not contract with any entity that is excluded from Medicare, Medicaid or any other federally funded program. Provider use of distributors or contracted supply companies is acceptable if the provider follows Medicare DMEPOS standards and Medicaid policy regarding delivery, record keeping and education on the use of the item(s).
- The provider must accept beneficiary returns of substandard, defective or unsuitable items.
- The provider must notify the beneficiary of warranty coverage, honor all warranties under applicable State law, and repair or replace free of charge Medicaid-covered items under that warranty.
- The provider must provide maintenance, replacement or repair at no charge to the beneficiary or Medicaid, either directly or through a service contract with another company, during the Medicaid rental period.
- The provider is responsible for delivery, set-up and education on the use of the DMEPOS item(s) and must maintain proof of delivery and education in the beneficiary file. The delivery ticket must include the beneficiary's (or beneficiary guardian/appointee's) signature and date as confirmation of receipt. Provider use of courier or shipping

services is acceptable if the DMEPOS provider follows current policy requirements for delivery, record keeping and education on the use of the item(s).

- The provider must answer beneficiary questions, respond to complaints, and maintain documentation of such contact(s) in the beneficiary file.
- The provider must have a complaint resolution protocol to address beneficiary complaints. Records of complaints must be maintained at the physical location. The complaint record must include the name, address, telephone number and Medicaid ID number of the beneficiary, complaint summary, and actions taken to resolve the complaint.
- All provider locations, whether owned or subcontracted, must meet the Medicare DMEPOS Supplier Standards (including, but not limited to, surety bond and liability insurance requirements) and Medicare quality standards.
- The provider must display on-site all licensing, certifications and accreditations, as applicable (out-of-state and borderland providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing).
- To be considered "in-state," the provider must have a physical storefront located within Michigan (or within the borderland areas of adjoining states). The location must be accessible to the public (including handicap accessible), be open for business for no less than 30 hours a week, be staffed during business hours, and maintain a visible sign with posted hours of business. Occupational therapists, physical therapists, and orthotic and prosthetic providers of custom orthotics and prosthetics are exempt from the 30 hour per week business rule but must comply with the accessibility and signage portions of the rule. (Out-of-state providers should refer to the Out of State/Beyond Borderland Providers subsection in the General Information for Providers Chapter for additional information.)
- The location must contain space for and have beneficiary records on site. For electronic health records, it is preferred that electronic health record systems be contained on the Certified Health IT Product List (CHPL) as published and maintained by the Office of the National Coordinator for Health Information Technology (ONC). Records must be made available upon MDHHS request.
- The location must display equipment/supplies provided and have inventory on site (custom-made items are exempt).
- The provider may not share space with other Medicare or Medicaid healthcare entities except for the following:
  - The provider is also enrolled as a pharmacy and owned by the same entity; or
  - The provider is hospital-owned and located within the hospital or a hospital-owned clinic.

NOTE: Separately identified physical space (e.g., clearly identified suites) within the same building is not considered "sharing space" if each space/location is recognized by the United States Postal Service (USPS) as a separate physical address.

Michigan Medicaid does not enroll warehouses or distribution centers as the function of these entities is to ship/store products and are not considered a storefront.

1.1.B. Complex Rehabilitation Technology (CRT) Provider [Subsection Added 4/1/2025]

In addition to the DME requirements in the Provider Enrollment subsection, CRT providers must be enrolled as a CRT provider and accredited with one of the Medicare Accreditation Organizations (AO) as a CRT provider. The CRT provider must have at least one employee who is a qualified CRT provider and is:

- Certified as a CRT professional by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) or by the National Registry of Rehabilitation Technology Suppliers (NRRTS).
- Participates in evaluations performed by a QHCP and the selection of appropriate CRT equipment/accessories.
- Provides beneficiary training in the proper use of the CRT equipment/accessories.
- Has the capability to provide servicing and repair for all CRT equipment/accessories the CRT provider offers.
- Upon delivery of CRT equipment/accessories, provides the beneficiary with written information regarding how to obtain service and repair.

The CRT provider is responsible for renewing their accreditation with the AO as required by the Centers for Medicare and Medicaid Services (CMS).

Non-CRT DME providers are approved on a case-by-case basis to provide CRT equipment and accessories when a CRT provider is not available in the beneficiary's geographic location. Non-CRT DME providers must comply with all the requirements indicated in the Provider Enrollment subsection. **(text added per bulletin MMP 24-58)**

1.2 MDHHS Medical Supplier/DME/Prosthetics and Orthotics Database

For specifics regarding the Healthcare Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.) Information includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, ICD diagnosis codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

1.2.A. Healthcare Common Procedure Coding System (HCPCS) Codes

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement, as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by HCPCS level I or Current Procedural Terminology (CPT) codes.

HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service. Decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment.

National permanent codes are maintained by the Centers for Medicare & Medicaid Services (CMS) HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. The permanent national codes serve the function of providing a standardized coding system that is managed jointly by private and public insurers.

National codes also include miscellaneous/not otherwise classified (NOC) codes. These codes are used when a medical supplier submits a bill or request for an item or service where there is no existing national code that adequately describes the item or service. Before using a miscellaneous/NOC code, the medical supplier should check with the Medicare Pricing, Data Analysis and Coding (PDAC) contractor to determine whether there is a specific code that should be used. (Refer to the Directory Appendix for contact and website information.)

When submitting a bill or request, medical suppliers are required to use HCPCS codes to identify items. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. MDHHS reserves the right to determine and apply correct HCPCS codes used for the purpose of reimbursement.

1.3 Face-to-Face (F2F) Visit Requirements

Section 6407 of the Patient Protection and Affordable Care Act (ACA) of 2010 and Section 504 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 require a face-to-face (F2F) visit with a physician or non-physician practitioner (NPP) prior to the initial written order for specific durable medical equipment and medical supplies. The Centers for Medicare & Medicaid Services maintains the list of specified items that require a face-to-face visit. The Durable Medical Equipment Face-to-Face List is posted on the MDHHS website. (Refer to the Directory Appendix for provider-specific webpage information.)

1.3.A. F2F Visit

Prior to the initial written order and delivery of selected durable medical equipment and medical supplies (some accessories), the beneficiary must have a face-to-face visit with a physician or NPP within six months prior to the initial written order. The visit must be related to the primary condition that supports the medical need for the equipment or supply. Telemedicine visits (refer to the Telemedicine Chapter) qualify as face-to-face visits. A new face-to-face visit is required for the following:

- Initial order for rental/purchase;
- New prescription/order,
- Replacement of the base equipment;
- When there is a change in the prescription/order of the item;

- When there is a change in the supplier of the item and the new supplier is unable to obtain a copy of the original order and documentation from the original supplier; and
- When there is change in state or federal law, policies or regulations.

1.3.B. Practitioners Who May Perform the Face-to-Face Visit

The face-to-face evaluation may be provided by a physician (MD or DO) or any of the following NPPs:

- Physician Assistant (PA)
- Certified Nurse Practitioner (NP)
- Certified Clinical Nurse Specialist (CNS)

Effective March 1, 2020, Interim Final Rule CMS-5531 permanently amends 42 CFR 440.70 (a)(2) to allow NPPs (i.e., PA, NP, and CNS), within their scope of practice, to perform face-to-face encounters, and document, certify and order Medicaid Home Health Services (including durable medical equipment, prosthetics, orthotics and medical supplies). The NPP is not required to communicate the clinical findings of the face-to-face encounter with the physician. Physician certification of the face-to-face encounter performed by an NPP is not required.

1.3.C. Physician or NPP Certification of the Face-to-Face Visit

The ordering physician or ordering NPP must certify that a face-to-face visit occurred within six months prior to the written order whether they performed the visit or another treating or attending physician or NPP performed the visit. The physician or NPP must document the date of the face-to-face visit and specify the name of the practitioner who performed the evaluation, document the clinical findings that support the need for the item(s), and confirm the primary reason for the visit that relates to the need for the item(s).

A treating or attending physician (e.g., inpatient hospital physician) or NPP may conduct the face-to-face visit and order the item(s) if all criteria of the face-to-face rules are met. If the treating or attending physician or NPP performs the face-to-face evaluation but does not write the initial order; they must communicate the details of the visit to the ordering physician or ordering NPP.

Documentation of the face-to-face visit may be indicated on the prescription/order, the certificate of medical necessity (CMN), or other medical record. A copy of the face-to-face visit must be kept in the beneficiary's file and the original sent to the durable medical equipment (DME) supplier. Upon receipt, the DME supplier must date stamp the face-to-face documentation and maintain the documentation in the beneficiary file. The face-to-face documentation must be available upon MDHHS request. For items requiring a prior authorization, the documentation of the face-to-face visit must accompany other required documentation with the prior authorization request.

1.3.D. Face-to-Face Prescriptions/Orders

MDHHS recommends the ordering physician or NPP include the face-to-face visit information on the written order or CMN; however, it is acceptable for this information to be indicated on other medical documentation (e.g. discharge summary). If the ordering physician or NPP chooses to document the face-to-face visit on the order, they must include the date of the visit, the name of the physician or NPP that performed the evaluation, and document the visit was related to the primary condition that supports the need for the item(s).

The face-to-face visit requirement applies to initial orders and not to supply refills, equipment repairs, the servicing of equipment, or to accessories (except for those accessories indicated on the CMS list). The ordering physician or NPP must assess the continued need for the medical supply or equipment on an annual basis. For refills of supplies, the ordering physician must indicate "renewal" on the order.

1.3.E. Billing Face-to-Face Items

For items requiring a face-to-face visit, the KX modifier must be appended to the HCPCS code on the claim. The KX modifier indicates that policy requirements have been met and that documentation is on file and available upon request. Adding the KX modifier on the claim if the face-to-face documentation has not been received and/or is not in the beneficiary file is incorrect billing and could result in post-payment recovery of funds or provider audit.

1.3.F. Home Health Agencies Providing Durable Medical Equipment, Prosthetics, Orthotics and Supplies

The ACA requires home health agencies (HHAs) to provide medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) either directly or through arrangement with DME providers when providing home health nursing or aide services.

Except for items identified in the Home Health chapter as routine medical supplies, and those items listed on the Home Health database as separately reimbursed to HHAs, HHAs choosing to provide DMEPOS must enroll with Medicaid as DME providers. HHAs must comply with all federal and state DMEPOS provider rules, policies, and regulations. (Refer to the General Information for Providers chapter and the Home Health chapter for additional information.)

1.4 Place of Service

Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in any non-institutional setting in which normal life activities take place except for skilled nursing facilities, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.

For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. Wheelchair requests for the primary purpose of meeting resident nursing care needs that are the responsibility of the nursing facility are not covered. Wheelchairs for

social or recreational purposes are the responsibility of the nursing facility. The Nursing Facility Chapter further describes coverage policy in the nursing facility. The following items are exempt from the per diem rate and must be billed by the medical supplier:

- Air-fluidized beds
- Bariatric beds
- Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.
- Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis)
- Orthotics and Prosthetics
- Parenteral nutrition, including all supplies, equipment, and solutions
- Powered air flotation bed (low air loss therapy)
- Selected surgical dressings
- Shoes and Additional Components

The medical supplier may deliver durable medical equipment, prosthetics, orthotics and medical supplies (DMEPOS) for beneficiary use in the beneficiary's home and community on the date of discharge from the skilled nursing facility (SNF) or nursing facility (NF). The SNF/NF is required to report the beneficiary date of discharge in the CHAMPS admission record. (Refer to the Beneficiary Eligibility Chapter for additional information.) To ensure DMEPOS items are not delivered prior to the facility discharge date and prevent beneficiary access to care issues, it is recommended that the SNF/NF and medical supplier coordinate the facility discharge date and DMEPOS delivery date.

To determine the acceptable place of service (POS) codes allowed for billing purposes, refer to the Billing & Reimbursement for Professionals Chapter of this manual.

In an outpatient facility, all equipment and services required for treatment during an emergency room or clinic visit are included in the reimbursement to the hospital (e.g., cervical collar, air cast).

In an inpatient hospital setting, services provided as part of the hospital care and treatment would be part of the DRG payment to the hospital (e.g., cervical collar or cast). Services provided to be used after discharge and delivered to the hospital to facilitate discharge may be reimbursed to the medical supplier (e.g., oxygen, walker, wheelchair).

MDHHS does not separately reimburse DMEPOS providers for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All DMEPOS services related to the beneficiary's terminal illness are either arranged for (via contract agreement) and reimbursed by, or provided by, the hospice program. Refer to the Hospice chapter for additional information about hospice services.

1.5 Age Factors

Coverage of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) may differ based on the beneficiary's age. When age factors exist, the DMEPOS provider can submit a prior authorization

request for consideration of coverage beyond the policy standards of coverage. For specifics of HCPCS codes and age parameters, refer to the Coverage Conditions and Requirements section and the Healthcare Common Procedure Coding System (HCPCS) Codes subsection of this chapter and to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

1.6 Medical Necessity

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS NP or PA. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDHHS standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

- The service/device meets applicable federal and state laws, rules, regulations, and MDHHS promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- The safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.
- The function of the service/device:
  - meets accepted medical standards, practices and guidelines related to:
    - type,
    - frequency, and
    - duration of treatment; and
  - is within scope of current medical practice.
- It is inappropriate to use a nonmedical item.
- It is the most cost effective treatment available.
- The service/device is ordered by the treating physician, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical

record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.

- The service/device meets the standards of coverage published by MDHHS.
- It meets the definition of Durable Medical Equipment (DME) as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

MDHHS does not cover the service when Medicare determines that the service is not medically necessary.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

1.6.A. Prescription Requirements

A prescription must contain all of the following:

- Beneficiary's name;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number or Social Security Number (SSN) (if known);
- Prescribing physician's, NP's or PA's name, address, and telephone number;
- Prescribing physician's, NP's or PA's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the service is needed; and
- Start date of order if different from the physician's, NP's or PA's signature date.

The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes, but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or healthcare practitioner's signed documentation.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis. (Providers must verify this information by referring to the beneficiary's eligibility letter received from CSHCS.)
- A physician subspecialist must sign the prescription if it is stated as required by the CSHCS Program in the Coverage Conditions and Requirements Section of this chapter.

MDHHS reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

Note: Refer to the Face-to-Face (F2F) Visit Requirements subsection for timelines, additional documentation requirements, and ordering/prescribing/evaluation requirements.

1.6.B. Automatic Refills

Automatically issuing refills of medical supplies to beneficiaries results in unnecessary expenditures and/or unused products.

The standard physician order for medical supplies is written for monthly refills. The beneficiary or their representative must verify that the refill is necessary and confirm any changes/modifications at the time the monthly refill is ordered.

Automatic refills of medical supplies without receiving prior customer approval or a request for a refill is considered program abuse. Subsequent refills should not be confirmed or issued any earlier than five to seven days prior to the end of the last monthly order.

For audit purposes, provider records should document this contact for products shipped to the beneficiary's home.

1.6.C. Documentation

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.6.D. Certificate of Medical Necessity Requirements

A CMN must contain all of the following:

- Beneficiary's name and address;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number (if initiated by the provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements section and the Face-to-Face (F2F) Visit Requirements subsection of this chapter.

MDHHS will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.

Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item.

1.7 Documentation in Beneficiary File

The medical supplier must maintain clean, reproducible copies of all required documentation for the specific medical device, including the physician's order, the MSA-1656 (and Addendum A and/or Addendum B, as applicable), the MSA-1653-B, and the MSA-1653-D in the beneficiary's file for seven years. For audit purposes, the supplier's records or beneficiary's medical record must contain the prescription and required documentation that substantiates the medical necessity of the item supplied. In addition to the prescription and any applicable documentation required, the provider must maintain on file:

- Equipment use logs or other provider required documentation as stated in the Coverage Conditions and Requirements Section of this chapter under Documentation for the item.
- For items purchased, proof of purchase (e.g., delivery slips, sales slips, vouchers).
- For items rented, set-up slips and pick-up slips with signature of beneficiary or legal representative, and maintenance records.
- For items shipped directly to the beneficiary, the date of delivery must be maintained in the records with delivery slip. It is the provider's responsibility to replace a service for which the beneficiary states was not received without additional cost to MDHHS or the beneficiary.
- Proof of education and instruction to beneficiary and/or caregiver regarding the proper usage of equipment and/or supplies when applicable (e.g., delivery slip signed by beneficiary).
- Documentation of the face-to-face visit (if applicable).

1.8 Prior Authorization

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-fabricated DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screens.
- Medical need for an item beyond the MDHHS Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required as noted in the Medicaid Code and Rate Reference tool.

Prior authorization coverage determinations are based on the evaluation of the documentation received and all of the following:

- The beneficiary's benefit plan scope and coverages (e.g., Emergency Services Only);
- Food and Drug Administration (FDA) and manufacturer product intended usage(s);
- Healthcare Common Procedure Coding System (HCPCS) Level II code definitions as deemed by the American Medical Association; and
- The safety and effectiveness of the product for age-appropriate treatment as substantiated by current evidence-based national, state and peer-review medical guidelines.

MDHHS reserves the right to a final determination of whether the practitioner's submitted medical documentation sufficiently demonstrates the medical necessity for the services requested.

Beneficiaries may request a fair hearing in accordance with 42 CFR Part 431 Subpart E for any MDHHS coverage denials. (Refer to the General Information for Providers chapter for additional information.)

1.8.A. Prior Authorization Form

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B) or, for mobility and custom seating items, submit the Complex Seating and Mobility Device Prior Approval-Request/Authorization form (MSA-1653-D). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must use the specific HCPCS code and the code description. A NOC code may not be used unless the use of a NOC code for the item has been approved by the PDAC. The brand, model, product or part number must be stated on MSA-1653-B or MSA-1653-D with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the Coverage Conditions and Requirements section of this chapter for additional information regarding standards of coverage and payment rule requirements.)

PA request forms and attached documentation may be mailed or faxed to the MDHHS Program Review Division. (Refer to Directory Appendix for contact information.)

Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.8.B. Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form [Change Made 4/1/2025]

CRT equipment and accessories requires the complex needs beneficiary to be evaluated by:

- A QHCP*:
- Physiatrist; or
- Licensed Physical Therapist; or
- Licensed Occupational Therapist; or
- A rehabilitation Registered Nurse (RN), who has at least two-years' experience in rehabilitation seating (if applicable); or
- Other licensed health care professional (e.g., physician, nurse practitioner, physician assistant, etc.) working within their scope of practice; and
- A qualified CRT professional (the CRT professional must be present at the time of the evaluation).

If a CRT professional is not available in the beneficiary's geographic location, the QHCP may perform the evaluation and coordinate provision of the equipment through an MDHHS-authorized non-CRT DME provider.

*The QHCP must not have a financial relationship with the CRT provider, unless the CRT provider is owned by a hospital and the QHCP is employed by the same hospital to work in the inpatient or outpatient setting. **(text added per bulletin MMP 24-58)**

The Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) provides a standard assessment tool for a licensed medical professional to use when performing assessments for wheelchairs, seating systems, and pediatric standing systems. The form is required for all ages and covered settings. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)

The MSA-1656 serves as a baseline evaluation for the beneficiary and is a clinical assessment that also includes an assessment of current technology options available to meet the beneficiary's medical and functional goals. The evaluation process assists the evaluator in determining the most appropriate level of equipment that will aid the beneficiary in completing mobility related activities of daily living (MRADL). Once problems and goals are determined, the process includes a patient simulation trial using comparable loaner or demonstration technology. The patient simulation is performed jointly by the clinician and a qualified assistive technology practitioner.

The initial MSA-1656 is retained on file by MDHHS. A new MSA-1656 is not required for additions or revisions to a seating system or mobility item unless there is a change in the beneficiary's functional status.

- Addendum A: Mobility/Seating – This form must be completed and submitted with MSA-1656 and MSA-1653-D when requesting complex seating, a manual wheelchair with

accessory add-ons, power wheelchairs, scooters, and power accessories. The evaluator must complete only the sections that apply to the requested equipment and accessories.

- Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs – This form must be completed and submitted with MSA-1656 and MSA-1653-D when requesting these items. The evaluator must complete only the sections that apply to the requested equipment and accessories.

Form completion instructions describe the responsibilities of the treating physician, the physical and occupational therapist, the medical supplier, and the nursing facility staff (when appropriate).

The MSA-1656 must be submitted within 90 days of the date the evaluation was completed. Completion/submission of the MSA-1656 without supporting documentation from the medical record is not acceptable. The use of medical supplier-created mobility forms or "canned" documentation statements are not acceptable and may not be used as a substitute for information from the medical record or for completion of required MDHHS forms.

The outpatient therapy provider or the nursing facility may bill for the mobility and seating assessment performed by the licensed medical professional using HCPCS code 97542.

1.8.C. Emergency Prior Authorization

A provider may contact MDHHS to obtain a verbal PA when the prescribing physician has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain a verbal PA, the provider may call the Program Review Division or fax a request. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.)

If an emergency service is required during nonworking hours (i.e., after 4:00 p.m., weekends, and State of Michigan holidays), the provider must contact the Program Review Division on the next available working day.

The following steps must still be completed before an actual PA number is issued for billing purposes:

- Submission of the PA request to MDHHS within 30 days of the verbal authorization. (Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.)
- Submission of the supporting documentation (e.g., prescription and CMN, physician letter, or applicable medical record).

The PA number will not be given for billing MDHHS and the provider will not be reimbursed if:

- The beneficiary was not eligible when the service was provided.
- A completed PA request (MSA-1653-B) is not received within 30 days of the verbal authorization.
- Required prescription and documentation is not received.
- The prescription and/or documentation are not signed within 30 days of the effective date.
- The prescription and/or documentation are not received within 30 days of the date of service (DOS).
- The medical need for the service is different than what was verbally given and does not fall within the Standards of Coverage.

Verbal authorization does not guarantee payment or eligibility.

1.8.D. Retroactive Prior Authorization

Services provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and the eligibility was made retroactive. If the MDHHS record does not show that retroactive eligibility was provided, then the request for retroactive PA will be denied.

1.8.E. Beneficiary Eligibility

Approval of a service on MSA-1653-B or MSA-1653-D confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDHHS will not reimburse the provider. To assure payment, the provider must verify eligibility prior to ordering or delivering the service. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

When equipment is prior authorized (if required) and ordered but not delivered before the loss of eligibility, MDHHS will pay for the service if the product is delivered within 30 days after the loss of eligibility.

1.8.F. Changes in Enrollment (FFS/MHP)

When beneficiaries change enrollment status (e.g., from managed care to FFS or FFS to managed care), the following applies:

- When custom-fabricated equipment (prosthetic or orthotic) is ordered for a beneficiary during a hospital stay but not delivered until discharge and enrollment changes, the payment must be made by the party responsible for the hospital stay.
- When a custom-fabricated, -fit, or -modified service is prior authorized and ordered by the provider before a change of enrollment, the party that authorized the service is responsible for payment. This responsibility only applies if the service is delivered within 30 days of the change of eligibility.

This policy does not apply to prefabricated, mass-produced, or ready-made items that can be used by a person other than for whom it is ordered. It also excludes rental items, all expendable/disposable medical supplies, or any item that does not require a length of time (days or weeks) to special order for a specific person.

1.8.G. Reimbursement Amounts

Most items have established fee screens that are published in the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule. The approved reimbursement amount of the fees for NOC codes and all codes without established fee screens will be indicated on the authorized PA request. For items that do not have established fee screens or are custom fabricated, refer to the Medicaid Code and Rate Reference tool for payment rules. (Refer to the Directory Appendix for website information.) The provider must provide a manufacturer's invoice that states the acquisition cost for the service on the PA request form. Manufacturer quotes or dealer list prices are not accepted as documentation of cost. Modified manufacturer invoices will not be accepted. If the manufacturer's actual invoice is not included, medical review will assign a penny screen to the code until the actual invoice is received. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form. MDHHS reserves the right to set a dollar limit on how much MDHHS will reimburse for a NOC code or any manually priced procedure code for a specific range of products.

Medicaid payment rates may not exceed those paid by Medicare. MDHHS will adjust its Medicaid fee schedule when Medicare rate changes result in noncompliance with this requirement. The changes will be reflected on the MDHHS Medical Supplier/DME/ Prosthetics and Orthotics Fee Schedule and in the Medicaid Code and Rate Reference tool. No notice will be issued directly to providers.

1.8.H. Billing Authorized Services

After an authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the invoice. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for complete billing instructions.)

1.8.I. Hospital Discharge Waiver Services

Hospital Discharge Waiver Services are DME items rented for the beneficiary in which the PA requirement is waived for up to the first three months after hospital discharge. If the beneficiary still requires these items after three months from hospital discharge, the PA requirement would still apply.

These items are as follows: HCPCS codes E0163, E0165, E0181, E0255, E0256, E0260, E0292, E0293, E0565, E0619, E0910, and E0940

1.8.J. Beneficiary Death Prior to Delivery

Reimbursement may be made for custom fabricated durable medical equipment, prosthetics, and orthotics (e.g. custom wheelchair seating system) not supplied due to the beneficiary's death prior to delivery or product completion. To be considered for reimbursement, the provider may contact the MDHHS Program Review Division (PRD) to request authorization for reimbursement of incurred costs. (Refer to the Directory Appendix for contact information.) Reimbursement will not be considered for prefabricated or off-the-shelf DMEPOS items.

Requests are made through the PRD Director and are determined on a case-by-case basis upon provider submission of supporting documentation including:

- original PA tracking number,
- beneficiary date of death,
- date the provider learned of beneficiary's death,
- invoice with itemized cost for materials, number of hours of labor (up to date the provider learned of the beneficiary's death) and any salvage value*, and
- provider statement of stage of fabrication completed.

*Salvage value applies when the provider can gain further profit by reusing materials/components for another device or by returning the materials/components to the manufacturer for credit. The salvage value must be clearly documented on the provider's invoice and deducted from the provider's usual and customary charge for the item. An example of an item with salvage value would be a prefabricated component such as a joint for a knee/ankle/foot orthosis.

MDHHS reserves the right to request other supporting documentation to substantiate provider incurred costs. The beneficiary must have been Medicaid eligible throughout

the original PA period, up to and including the date of death. The provider must submit an official invoice to receive reimbursement and not a quote.

The PRD Director will determine the date of service within the date range of the initial approved PA up to the beneficiary's date of death. MDHHS will not approve requests past the authorization period of the original approved PA request.

1.9 Durable Medical Equipment

1.9.A. Standard Equipment and Custom-Fabricated Seating

Standard equipment and custom-fabricated seating must be medically necessary and meet the medical and/or functional needs of the beneficiary.

- Standard equipment and accessories are products ordered from manufacturer stock. Measuring and custom-fitting a medical device to a beneficiary or custom-assembling a medical device to fit a beneficiary's needs using manufactured stock pieces is not considered to be custom-fabricated.
- Custom-fabricated seating is made from clinically derived, rectified castings, tracings, and other images (such as x-rays) of the beneficiary's body part.

  It also includes computer-aided design/computer-aided manufacturing (CAD/CAM) technology used for the seating system. Computer-aided design/manufacturing must be performed by an experienced clinician along with a Certified Rehabilitation Technology Supplier (CRTS) or Assistive Technology Professional (ATP) who has completed the training course offered by the manufacturer. The outcome should be created jointly by the clinician and the CRTS/ATP. The cost for performing these activities is included in the Medicaid payment rate for the custom-fabricated seating system.

MDHHS will only consider coverage of custom-fabricated seating when a standard item will not meet the medical or functional needs of the beneficiary. All custom-fabricated equipment requires prior authorization. Once the custom-fabricated equipment is purchased, it becomes the property of the beneficiary. To be covered as custom-fabricated, the item must meet the MDHHS definition of custom-fabricated. A manufacturer's use of the term custom-fabricated for an item that does not meet the MDHHS definition will not be reimbursed as custom-fabricated. MDHHS reserves the right to determine and apply HCPCS codes used for the purpose of reimbursement.

1.9.B. Payment Rules: Rental and/or Purchase

Generally, equipment will be purchased when a beneficiary requires the equipment for an extended period of time. For prior authorized services, the PA consultant may change the authorization request from a rental to a purchase or a purchase to a rental based on the documentation submitted. If DME items are purchased, the provider must indicate whether the DME item provided is new or used, as appropriate. The provider should refer to the Payment Rules described in the Coverage Conditions and Requirements Section of this chapter for MDHHS policy on specific services.

Purchase (New or Used) - Items may be purchased if they are inexpensive accessories for other DME equipment or the equipment itself will be used for an extended period of time.	To be reimbursed for **new** equipment, the provider must: ▪ Adhere to all aspects of the manufacturer's warranty, including all routine servicing; ▪ Deliver, set-up and install the equipment in the home, if applicable; ▪ Instruct the beneficiary or caregiver in the use and general care of the item; and ▪ Complete all adjustments and/or modifications needed to make the item functional. To be reimbursed for **used** equipment, the provider must: ▪ Ensure that the used equipment is fully serviced and in good operating condition; ▪ Include all routine servicing for the equipment into the purchase price of the item for a minimum of one year; ▪ Instruct the beneficiary or caregiver in the use and general care of the item; and ▪ Not allow the cost of its maintenance to exceed the cost of new equipment.
Rental - The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.	**Rental Only** – Items that require regular and ongoing servicing/maintenance would be rented for the duration indicated by the physician's order. Examples are oxygen, apnea monitors, and volume ventilators.
	Capped Rental – Items rented until purchase price is reached. For Medicaid, items may be rented for a maximum period of 10 months. If the provider has been reimbursed for 10 months of rental, the item is considered purchased. (If used equipment is issued to the beneficiary, the usual and customary charge reported to Medicaid must accurately reflect that the item is used.)
	Converting Rental to Purchase – The majority of DME items can be rented as a capped rental for up to a maximum of 10 months. If the purchase of an item is requested after an initial rental period has occurred, the provider must subtract the amount already paid for the rental item from the total purchase price.

1.9.C. Repairs and Replacement Parts [Change Made 4/1/2025]

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDHHS purchased the item. If MDHHS did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply loaner equipment while the beneficiary-owned item is being serviced at no charge to MDHHS. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDHHS will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

The repair and/or replacement of CRT equipment and accessories is limited to DME providers that are enrolled with Medicaid as a CRT provider. Non-CRT providers are approved on a case-by-case basis when an enrolled CRT provider is not available in the beneficiary's geographic location. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)**

Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDHHS as a rental.

Modifiers to be used when requesting replacements/repairs are as follows:

Modifier	Description
RA	Replacement of a DME, orthotic or prosthetic item
RB	Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. For repairs to wheelchairs, refer to the Wheelchair Repair/Labor Guide posted on the MDHHS website, and to the Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices subsection of this chapter. The RB modifier is required.

For a repair in which no specific HCPCS code is appropriate, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. The RB modifier is reported for the replacement part of the DME furnished as part of the repair. PA is required. The provider must provide a manufacturer's invoice that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.

The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDHHS will consider replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section of this chapter apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.

The RA modifier should be reported with the appropriate HCPCS code of the DME to be replaced and should be reported when replacing a DME item with an identical or nearly identical item.

MDHHS will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-fabricated service in lieu of the availability of a code to cover a prefabricated item.

1.9.D. USED EQUIPMENT

Definition	Used durable medical equipment is defined as non-customized equipment previously purchased or rented by one or more users, or equipment utilized as floor models, demonstration equipment or loaner equipment prior to current purchase or rental.
Standards of Coverage	Used equipment may be covered when all of the following are met: ▪ The provider determines the item to be the least costly alternative that meets the beneficiary's medical/functional needs; and ▪ The equipment and components are non-customized items; and ▪ The equipment is not intended or labeled as a single user item; and

	▪ The equipment is in good working condition and comparable to new equipment quality standards; and ▪ The equipment has been sanitized, repaired and reconditioned between each user. Prior to the provision of used equipment, the beneficiary/parent/legal guardian must be given a choice to accept or refuse used equipment. If the beneficiary chooses to not accept the used equipment, the provider must provide new equipment following the standards of coverage and payment rules indicated in policy. MDHHS suggests that used equipment be identified by affixing a tag to the item with the equipment age and make/model/serial number or other identifying information. Providers offering used equipment are responsible to clean, repair and recondition used items between users to assure the equipment is safe and in good working condition. The provider must remove used items from service when such items no longer meet quality standards.
Documentation	In addition to documentation requirements listed in the this chapter, documentation for used equipment must include: ▪ Equipment service log ➢ Confirmation that the equipment has been fully serviced and is in good working condition; ➢ Repair(s) and sanitization dates, with signature(s) of person(s) performing these functions; ➢ Age of item (if known); ➢ Serial number/make/model (or other identifying information); and ➢ Warranty information. The above information must be incorporated into the beneficiary's file upon rental/purchase of the item. ▪ Beneficiary file ➢ Signed and dated agreement from the beneficiary/parent/legal guardian stating they understand the equipment is used; ➢ Indication that a manufacturer's owner's manual was provided to the beneficiary; and ➢ Provider attestation that the used equipment is durable enough to meet Medicaid minimum frequency limits for replacement equipment. Documentation must be available upon MDHHS request. Refer to the specific policy standards of coverage and documentation requirements listed in this chapter.
PA Requirements	Prior authorization is not required for used equipment if PA is not required for a new item with the same HCPCS code assignment. PA is required for coverage beyond the standards of coverage, repair/replacement rules, and frequency limits indicated for the specified equipment.

Payment Rules	Used equipment may be purchased or rented (up to specified rental periods listed in policy). Repairs/reconditioning/sanitizing and labor costs are included in the initial purchase and rental period per each beneficiary. All warranties must be exhausted prior to requesting prior authorization for repair or replacement of the equipment per beneficiary. MDHHS has identified specific items that must have either the NU or UE modifier appended to the HCPCS code when requesting PA or submitting a claim. Failure to append the correct modifier(s) may result in denied claims or inaccurate payment. ▪ NU - New Equipment ▪ UE - Used Equipment Refer to the Medical Supplier database and/or the Medicaid Code and Rate Reference tool for HCPCS codes requiring the NU or UE modifier.

1.10 Prosthetics and Orthotics

For custom-fabricated prosthetics and orthotics (P&O), MDHHS reserves the right to request a recommendation from an appropriate physician subspecialist, physical therapist (PT) or occupational therapist (OT) evaluation when necessary to determine the functional and/or medical need for the item requested.

1.10.A. Noncustom versus Custom-Fabricated

Noncustom orthotics are prefabricated, available off the shelf for use, require basic measurements, and could include simple or minor custom fitting if necessary. Any delivery or service charges, fitting and preparatory procedures are considered part of the total purchase charge. Custom-fabricated P&O require measurements, fitting, casting or recasting, or molding to allow the appliance to meet the specific functional needs of the beneficiary. It may involve the incorporation of some prefabricated components. Adding prefabricated components to a prefabricated item is not considered custom-fabricated. Selection of the procedure code should be based on the service provided. Custom codes should not be used for prefabricated services.

All orthotist and prosthetist providers must have facility accreditation through any of the CMS-approved AOs in order to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their accreditation and be able to provide proof upon request. Orthotic and prosthetic providers must only bill specific prefabricated and custom-fitted orthotics that may include simple or minor intervention.

Medicaid will consider coverage of these services when provided by other types of practitioners in which the service is within their scope of current medical practice.

1.10.B. HCPCS Modifiers - Left and Right Side of the Body

The LT or RT modifier must be reported for orthoses and prostheses to designate either the left or right side of the body, if applicable. The frequency limits are based on the individual item being replaced. If the same code is used bilaterally on the same date of service, the modifiers LT and RT must be entered on the same line of the claim listing the appropriate combined quantities. To determine whether a procedure code requires the LT or RT modifier, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-fabricated service in lieu of the availability of a code to cover a prefabricated item.

1.10.C. Adjustments, Replacements and Repairs

Adjustments related to the delivery of orthoses are considered as part of the purchase price and are not separately reimbursable up to 90 days following placement. Providers are still responsible for the replacement, modification, and adjustment of any orthotic or prosthetic item that they placed but was not fitted properly. It is expected that the provider will adjust the device if possible before billing the program for modifications or replacements when there is unexpected growth spurt, substantial weight loss or gain, or post surgery.

Replacement of a component part of an orthosis includes the cost of the part and the labor associated with its removal, replacement and finishing.

For a repair in which no specific HCPCS code is appropriate, bill for the actual time it takes to repair or adjust the device and for the minor materials used. Report the labor charge by using HCPCS code L4205 (for orthoses) or HCPCS code L7520 (for prostheses). For minor materials used in repairing the item, report HCPCS code L4210 (for orthoses) or HCPCS code L7510 (for prostheses). MDHHS will cover the acquisition cost of material, not the provider's charge.

1.11 Noncovered Items

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Custom seating for secondary and/or transport chairs

- Devices used for play, pre-mobility development, or exercise are not considered pediatric mobility devices for the purpose of reimbursement and are not covered (e.g., jet mobile, ready racer, creepster crawler)
- Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Equipment for social or recreational purposes
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Hand/body wash
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Ice packs
- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g., insulin pump)
- Items that are not defined by the American Medical Association (AMA), the Food and Drug Administration (FDA), and the Pricing, Data Analysis, and Coding (PDAC) contractor as medical devices or dedicated durable medical equipment (e.g., personal tablets, computers, iPads, iPhones, Smart devices, etc.)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Padded footplates
- Peri-wash
- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0

- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- Room dehumidifiers
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)
- Second units for school use
- Second wheelchair for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formula
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- UV lighting for Seasonal Affective Disorder
- Vacu-brush toothbrushes
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the Coverage Conditions and Requirements Section of this chapter or the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information.

1.12 Charging the Beneficiary

The provider may not charge the beneficiary for failure to provide sufficient documentation to support coverage or failure to obtain PA. The provider may charge the beneficiary if the beneficiary waives their right to PA. The provider must maintain on file a document that demonstrates that the beneficiary knew and understood that the waiver of PA would result in the beneficiary's responsibility for payment. In addition, the provider may not charge the beneficiary any copayments (unless permitted by Medicaid) or charges above the Medicaid allowable amount.

1.13 Uniform Reporting of Services

MDHHS follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.

SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

2.1 APNEA MONITOR

Definition	An apnea monitor measures both heart rate and respirations and meets all of the Equipment Control Regulatory Industry (ECRI) Standards for home monitors.
Standards of Coverage	**A Newborn Infant Following Hospital Discharge –** Units are covered for a newborn infant up to three months following hospital discharge if one of the following diagnoses or medical conditions applies: ▪ Apnea of newborn ▪ Apnea of prematurity ▪ Apparent life threatening event (ALTE) ▪ Sibling of Sudden Infant Death Syndrome (SIDS) ▪ Bronchopulmonary Dysplasia
	A Sibling of Sudden Infant Death Syndrome (SIDS) Following Hospital Discharge – ▪ Units are covered for up to one month past the age of the sibling who died from SIDS; or ▪ Up to three months past the age of the sibling who died if the child was a twin of the beneficiary being monitored.
	An Acute Respiratory Illness - Short-term coverage of a unit (up to two months) is a benefit when the beneficiary has a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia.
	As a Diagnostic Tool - Short-term coverage of a unit (up to three months) used as a diagnostic tool is a benefit if the infant is under three months of age at set-up, and the parent and/or guardian reports suspected events.
	Beneficiaries with Tracheostomy – Units are generally not covered for beneficiaries who have a tracheostomy. Units may be considered for coverage only if, after careful evaluation of current treatment plan and equipment already in the home, the beneficiary's medical needs are still not met. Documentation explaining the medical need must be submitted with a detailed plan of management.
	Beneficiaries who are Ventilator Dependent - Units are considered to be included in the ventilator reimbursement to function as a backup alarm for the ventilator low-pressure alarm.

Noncovered Conditions	Units are not covered for the following diagnoses/medical conditions unless documentation justifies medical necessity and usage meets the established Standards of Coverage above: ▪ Chromosomal abnormalities ▪ Congenital heart defects with or without arrhythmias ▪ Cerebral palsy ▪ Asymptomatic prematurity ▪ Developmental delay/intellectual disability ▪ Seizure disorder ▪ Hydrocephaly with or without Arnold-Chiari Syndrome ▪ Irreversible terminal conditions ▪ Distant family history of SIDS (other than immediate sibling)
Documentation	The documentation must be less than 30 days old and include all of the following: ▪ A statement from an appropriate subspecialist trained in the treatment of apnea (i.e., apnea clinic, neonatalogist, pediatric intensivist, pediatric pulmonologist, or neurologist) medically substantiating the continued need for the unit. ▪ Download interpretation of the monitor data documenting continued apnea or bradycardia events. ▪ For a sibling of SIDS, the age of the sibling at death.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: ▪ Up to three months usage for newborn infants following a hospital discharge. ▪ Up to three months usage for siblings of SIDS following a hospital discharge. ▪ Used up to two months due to a respiratory illness (e.g., Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia). ▪ Used up to three months as a diagnostic tool for the following diagnoses or medical conditions: ➢ Apnea of newborn ➢ Apnea of prematurity ➢ Apparent life threatening event (ALTE) ➢ Sibling of Sudden Infant Death Syndrome (SIDS) ➢ Bronchopulmonary Dysplasia
	PA is required for the following: ▪ Continuation of the monitor beyond the initial two or three months. ▪ Other diagnoses/medical conditions or applications not indicated in the Standards of Coverage.

Payment Rules	An Apnea Monitor is considered a **rental only** item and includes all of the following: ▪ All accessories needed to use the unit (e.g., electrodes, lead wires, belts, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading/interpretation of recorded data.

2.2 Bi-Level Positive Airway Pressure Device

Definition	The bi-level positive airway pressure (BIPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts. The device has two pressure levels (one for breathing in and one for breathing out).
Standards of Coverage	A BIPAP device **without the backup rate feature** may be covered for the following conditions for up to four months: ▪ For Obstructive Sleep Apnea (OSA), if the sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ➢ Continuous airway pressure of 13-15 cm water does not adequately control/eliminate obstructive/hypopneic events; or ➢ The beneficiary cannot tolerate continuous positive airway pressures of greater than or equal to 12 cm water, in addition to evidence that the sleep lab has worked with the beneficiary to try different application devices, ramp times, relaxation techniques, etc. ▪ For respiratory failure if there are lab values (i.e., arterial blood gas [ABG], venous blood gas [VBG] or capillary blood gas) indicating respiratory failure and follow-up lab values documenting improvement with the use of a BIPAP. ▪ For a diagnosis/medical condition for which a CPAP is inappropriate for use (e.g., cardiomyopathy, corpulmonale, primary pulmonary hypertension, left ventricular hypertrophy, etc.).
	A BIPAP device **with the backup rate feature** may be covered if the beneficiary requires the backup feature due to insufficient spontaneous respiratory efforts (e.g., inadequate negative respiratory force due to central apnea, neuromuscular diseases such as muscular dystrophy, etc.).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis related to the need for BIPAP. ▪ BIPAP settings and number of hours per day used. ▪ Other medical conditions ruling out the appropriate use of a CPAP if present (e.g., cardiomegaly, left ventricular hypertrophy, primary pulmonary hypertension, etc.). ▪ For diagnosis of OSA, results of a sleep study (polysomnogram) including CPAP/BIPAP titration. ▪ For diagnosis of respiratory failure, test results substantiating the condition (e.g., ABG, VBG, or capillary blood gas) as well as test results showing improvement on BIPAP.

	▪ Negative inspiratory force measurement, if appropriate. For continued coverage beyond the initial four months, the following additional information must be provided: ▪ Medical statement indicating beneficiary is stable and the BIPAP device settings are adequate. ▪ Documentation of beneficiary compliance through the review of equipment use logs.
PA Requirements	PA is required for all BIPAP requests.
Payment Rules	BIPAP units are considered a **capped rental** item and are inclusive of all of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.3 BLOOD PRESSURE MONITORING

Definition	Blood pressure monitoring includes manual (sphygmomanometer/blood pressure apparatus with cuff and stethoscope) and automatic blood pressure devices.
Standards of Coverage	Manual or automatic blood pressure monitors are covered for beneficiaries of any age with uncontrolled blood pressure when all the following are met: ▪ The treatment plan requires the beneficiary to self-monitor and record blood pressure readings at a minimum of once daily; ▪ The beneficiary has any of the following conditions: ➢ History of heart disease, congenital heart defects, or stroke ➢ A neurological condition that affects blood pressure ➢ A medication regimen is present that affects blood pressure ➢ Blood pressure fluctuations due to renal disease ➢ Medications are titrated based on daily blood pressure readings ➢ Hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia) ➢ Hypertension, despite beneficiary compliance with the treatment plan (i.e., adherence to medication regimen, dietary changes, smoking cessation, etc.); ▪ The ordering practitioner or practitioner's nursing staff have educated the beneficiary on self-measurement of blood pressure, recording blood pressure readings, have fit the beneficiary with the appropriate cuff size, and have provided or referred the beneficiary for follow-up education as necessary; and

	▪ The medical supplier has provided further education regarding use of the monitor/cuff, cleaning/maintenance, warranty information, troubleshooting errors, and the medical supplier's contact information for repairs/replacement or assistance for equipment malfunction. An automatic blood pressure monitor is recommended rather than a manual blood pressure monitor unless the beneficiary has an adult family member/caregiver available to assist the beneficiary in taking blood pressure using a manual blood pressure monitor. The family member/caregiver must be instructed by the beneficiary's practitioner or practitioner's staff regarding proper use of the blood pressure monitor. The blood pressure monitor must be registered with the U.S. Food & Drug Administration. Reference the American Medical Association (AMA), U.S. Blood Pressure Validated Device Listing of blood pressure monitors that meet the AMA's criteria for clinical accuracy. The list is available on the AMA website; refer to the Directory Appendix for website information. Provision of the link to the AMA validated device list is for provider informational purposes only. Medicaid blood pressure monitor coverage is not contingent upon the requested device being validated by the AMA.
Non-Covered Items	▪ Finger and wrist monitors
Documentation	The documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition pertaining to the need for the blood pressure monitor. ▪ Complete practitioner's treatment plan, including current blood pressure medications, frequency of checks, lifestyle changes (i.e., diet, exercise, etc.), and specific patient protocol in case of an abnormal reading. ▪ Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (**required for coverage under CSHCS**).
Frequency	One blood pressure monitor (manual or automatic) may be purchased within a five-year period. The blood pressure cuff may be replaced once every two years.
PA Requirements	Prior authorization is not required for the following when Standards of Coverage are met, and the beneficiary has one of the following diagnoses/conditions: ▪ renal disease; or ▪ hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia). Prior authorization is required for the following: ▪ Medical need beyond the standards of coverage. ▪ Diagnoses/conditions other than those listed above. ▪ Replacement of the monitor and/or accessories prior to frequency limitations.
Warranty	Manual and automatic blood pressure monitors must have a minimum of a one-year warranty.
Payment Rules	A blood pressure monitor is considered a purchase only item and includes all accessories necessary for operation of the monitor. Any warranties must be expired prior to requesting replacement of the monitor or accessories. Refer to the Medicaid Code and Rate Reference tool for HCPCS code coverage parameters. (Refer to the Directory Appendix for website information.)

2.4 Breast Pumps

Medicaid covers hospital-grade electric, personal use double electric, and manual breast pumps.

2.4.A. Hospital-Grade Electric Breast Pump

Definition	A hospital grade electric breast pump is heavy duty, piston-operated, and is capable of being used frequently on a daily basis.
Standards of Coverage	A hospital grade electric breast pump may only be covered for a beneficiary with a Neonatal Intensive Care Unit (NICU) infant, up to three months of age, when one of the following applies: ▪ The infant has a severe feeding problem secondary to cleft lip and/or palate. ▪ The infant has a severe feeding problem due to oral motor dysfunction, secondary to prematurity. ▪ The infant is hospitalized resulting in a physical separation of the mother and infant. ▪ The infant or mother is hospitalized, resulting in a physical separation of the mother and infant; and all of the following applies: ➢ The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable); ➢ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma; ➢ The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute; ➢ The pump must be able to operate on a 110-volt household current and be UL listed; ➢ The pump must not weigh over 12 pounds; and ➢ The pump is registered and cleared with the FDA. For continued coverage beyond the initial three months, additional documentation must be provided.
Documentation	Documentation must be less than 30 days old and include: ▪ Diagnosis/medical condition of the infant relating to the need for a breast pump. ▪ Infant's age (gestational age, if premature). ▪ Mother's discharge date. ▪ Anticipated duration of need. ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Documentation of mother's intent to breastfeed. Documentation must be kept in the beneficiary's file and made available upon request.

PA Requirements	PA is not required when the Standards of Coverage are met.
	PA is required for coverage beyond three months.
Payment Rules	A breast pump is considered a **rental only** item and is inclusive of the following: ▪ All related accessories necessary to use the equipment. (To obtain additional reimbursement for the initial breast pump kit, report the "KH" modifier with HCPCS code E0604 for the first month of rental only.) ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. The rental pump may be billed using the infant's Medicaid ID number if the need for the hospital grade pump meets the standards of coverage and the mother loses Medicaid eligibility. Rental of the hospital-grade electric breast pump will not be made if a personal use double electric breast pump or a manual breast pump was purchased for the beneficiary within the Standards of Coverage frequency limitations.

2.4.B. Personal Use Double Electric Breast Pump

Definition	A personal use double electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user, capable of being used frequently on a daily basis.
Standards of Coverage	A personal use double electric breast pump may be covered once per five years for a beneficiary when all of the following criteria are met: ▪ The mother expresses the desire to breastfeed; ▪ The pump has been registered and cleared by the FDA; ▪ The pump has a minimum of a one-year manufacturer's warranty; ▪ The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable); ▪ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma; ▪ The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute; ▪ The pump must be able to operate on a 110-volt household current and be UL listed; ▪ The pump must not weigh over 12 pounds; and ▪ The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.

Documentation	Must be less than 30 days old and include all of the following: ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Infant's age (gestational age, if premature). ▪ Mother's hospital discharge date or infant's hospital discharge date. ▪ Documentation of mother's intent to breastfeed. Documentation must be kept in the beneficiary's file and made available upon request.
PA Requirements	PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.
Payment Rules	All personal use double electric breast pumps are purchase only. Payment includes: ▪ Education for the proper use, care of the equipment, and storage of breast milk. ▪ Supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes. The pump may be billed using the infant's Medicaid ID number if the need for the pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a personal use double electric breast pump during the rental period of a hospital-grade electric breast pump or if a manual breast pump was purchased within the Standards of Coverage frequency limitations. Replacement parts are covered after the manufacturer's warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.

2.4.C. MANUAL BREAST PUMP

Definition	A manual breast pump typically consists of a single breast shield, a collection device, and a hand-controlled lever to create suction and express milk. Manual breast pumps are intended for a single user.
Standards of Coverage	A manual breast pump may be covered once per birth. For a beneficiary who has had a multiple birth delivery, only one pump is covered. Coverage of a manual breast pump may be provided when all of the following criteria have been met: ▪ The mother expresses the desire to breastfeed. ▪ The pump has been registered with the FDA. ▪ The pump has a minimum of a one year manufacturer's warranty. ▪ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma. ▪ The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.

Documentation	Documentation must be less than 30 days old and include all of the following: ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Infant's age (gestational age, if premature). ▪ Mother's hospital discharge date or infant's hospital discharge date. ▪ Documentation of mother's intent to breastfeed. Documentation must be kept in the beneficiary's file and made available upon request.
PA Requirements	PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.
Payment Rules	All manual breast pumps are purchase only. Purchase includes: ▪ Education for the proper use, care of the equipment, and storage of breast milk. ▪ Supplies necessary for the operation of the pump (pump, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). The pump may be billed using the infant's Medicaid ID number if the need for the pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a manual breast pump during the rental period of a hospital-grade electric breast pump or if a personal use double electric breast pump was purchased within the Standards of Coverage frequency limitations. Replacement parts are covered after the manufacturer's warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.

2.4.D. Non-Covered Breastfeeding Items

Non-covered breastfeeding items:

- Personal use single electric breast pumps
- Breastfeeding pillows
- Breastfeeding comfort items and clothing
- Accessories not necessary for the operation of the breast pump

2.5 Canes and Crutches

Definition	Canes or crutches include, but are not limited to, adjustable or fixed canes, quad or three prong canes, forearm crutches and underarm crutches.
Standards of Coverage	Canes or crutches are covered if: ▪ The diagnosis/medical condition results in instability in ambulation or inability to ambulate. ▪ The beneficiary requires the stability of a cane or crutch to ambulate.

Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to instability or inability to ambulate. ▪ Type of item requested. ▪ Medical reason for replacement (when appropriate).
PA Requirements	PA is not required when Standards of Coverage are met.
	PA is required when: ▪ The beneficiary is over the age of 21, and replacement is required within five years. ▪ The beneficiary is under the age of 21, and replacement is required within one year. For replacement of pads, handgrips or tips, the provider may call for a verbal authorization. The provider must provide acquisition cost supported by a manufacturer's invoice. A prescription is not required if the program has covered the cane and/or crutch. The original prescription for the item must be kept on file.
Payment Rules	Canes and crutches are considered **purchase only** items.

2.6 Children's/Adolescent Products [Change Made 7/1/2025]

Definition	Children's/adolescent products are specialized equipment used in the home or vehicle for children with disabilities or medical conditions for the purposes of positioning, safety during activities of daily living, or assisted mobility. Specialized children's products include, but are not limited to, the following: activity chairs, bath supports, adaptive specialized car seats, corner chairs, standers, gait trainers, walkers, commodes, and toileting supports. The terms "child", "children", "children's" "adolescent", and "adolescents" are used interchangeably throughout this policy but apply to both age groups.
Standards of Coverage (All Children's/ Adolescent Products)	Children's/adolescent products are covered when the following are met: ▪ Commercial products or other less supportive positioning/mobility aids cannot address the child's medical/functional need. ▪ The requested product(s) can accommodate growth for a minimum of two years (e.g., fit and/or adapt for growth). ▪ The parent(s)/legal guardian has received training on safe use, care of the product, and is willing and able to follow the treatment plan (for adaptive specialized car seats, training must include proper vehicle installation/removal of the car seat). ▪ The product is for use in the family home (exceptions: car seats are intended for use in the family vehicle, gait trainers and walkers are intended for use in the home and in the community [where functionally appropriate]). ▪ The product(s) is the least costly alternative that meets the child's medical/functional need. Refer to the subsections of this policy for additional product-specific standards of coverage.

Parent(s)/Legal Guardian Agreement/Consent	The parent(s)/legal guardian (as applicable) must approve of all equipment prior to delivery or if prior authorization is required before the durable medical equipment (DME) provider submits the prior authorization request. All children's products (e.g., activity chairs, bath, and toileting equipment) are expected to be used within the child's primary residence (except mobility items as these items are intended to be used in all environments the child frequents). The parent(s)/legal guardian's approval of equipment is especially important when recommending multiple pieces of equipment to be used within the home. Providers must ensure the equipment can fit in the home and be used within the intended space (e.g., the shower chair can fit through the bathroom door, can be moved, or leave ample space if other family members use the same bathroom). If the delivered equipment does not fit in the intended space, the child is unable to use the equipment, or it does not properly fit the child, the item is considered unsuitable and the DME provider must accept return of the item(s). Refer to the Provider Enrollment subsection of this chapter regarding beneficiary returns. The DME provider must obtain the parent(s)/legal guardian's approval for each piece of equipment via the parent(s)/legal guardian's signed and dated written statement or on the DME provider's generated document. The parental/legal guardian signature may be either handwritten or digitally drawn. The signed and dated approval must be kept in the beneficiary file and, if prior authorization is required, submitted with the prior authorization request. **(text revised per bulletin MMP 25-05)**
Documentation (Applies to All Children's/ Adolescent Products)	Documentation must be less than 180 days old and include the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home. ▪ Statement of functional need from an appropriate pediatric subspecialist, occupational or physical therapist. ▪ Signed and dated parent(s)/legal guardian agreement/consent. ▪ Beneficiary-specific explanation of why the requested equipment is required, the child's medical/functional limitations during activities in which the equipment will be used, and what similar economic alternatives have been trialed, considered, and ruled out. Medicaid will consider requests for multiple devices on a case-by-case basis; however, documentation submitted with the prior authorization request must indicate the reason why one device alone will not meet the child's medical/functional need. **Note:** Children's Special Health Care Services (CSHCS) beneficiaries require a prescription from a CSHCS-authorized physician subspecialist. Refer to the Children's Special Health Care Services chapter of this Manual for additional information. All required documentation indicated in this chapter and in the children's/adolescent products policy must be kept in the beneficiary's file and be available upon request. Failure to keep required documentation in the beneficiary's file may result in audit and/or post payment recovery of funds.
Warranty	All children's/adolescent products must have a minimum one-year warranty. The warranty period must be expired prior to requesting repair or replacement of the product.
PA Requirements	Refer to the subsections of this policy for additional product-specific prior authorization requirements.
Payment Rules	Refer to the subsections of this policy for product-specific payment rules.

2.6.A. Specialized Adaptive Car Seats [Change Made 4/1/2025]

Definition	A specialized adaptive car seat is a non-standard children's car seat that is designed specifically for children with special needs to address positioning and safety during vehicle transport when the child cannot be safely transported or positioned using a standard commercial car seat/booster seat.
Standards of Coverage	A specialized adaptive car seat may be covered for the purpose of safety and supportive positioning in the family vehicle when **one** or more of the following applies to the child/adolescent: ▪ Has unstable head and/or trunk control. ▪ Is unable to independently maintain a seated position. ▪ Is in a spica cast and cannot fit in a commercial infant/child car seat/booster seat. ▪ Has a condition that results in uncontrolled movement (e.g., seizure) or positioning change, and the following: ➢ Has outgrown or cannot be positioned or safely transported using a standard commercial infant/child car seat/booster seat (federal and state age-related vehicle seating safety laws apply). ➢ the child's weight and height meet the manufacturer's product weight/height requirements. The provision of specialized adaptive car seats is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/ Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)**
Documentation	Documentation must be less than 180 days old and include **all** the following: ▪ Diagnosis appropriate for the requested car seat. ▪ Other adaptive equipment or assistive devices currently used for mobility/transport and why those items do not meet the child's transport needs. ▪ The MSA-1656 (Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices) and corresponding Addendum B. (Refer to the MSA-1656 Instructions in the Forms Appendix of this Manual.)
PA Requirements	Prior authorization is required for all specialized adaptive car seats.
Non-Covered	▪ An additional car seat for use in other family vehicles. ▪ Bases to make the car seat "mobile." ▪ Accessories/options not part of the safety features of the car seat, do not assist with positioning, or that are not related to modifying the car seat for growth purposes. ▪ A car seat for use beyond its intended function as a car seat.
Payment Rules	Specialized car seats are considered **purchase only** items.

2.6.B. Activity/Positioning Chairs [Change Made 4/1/2025]

Definition	Activity/positioning chairs are specially designed equipment for use in the home for children with disabilities or medical conditions who are unable to maintain a seated

	position independently without support to perform activities of daily living. Examples of activity/positioning chairs include, but are not limited to, the following: corner chairs, feeder seats, hi-lo chairs, floor sitters and adjustable highchairs.
Standards of Coverage	Activity/positioning chairs are covered for children when **one** or more of the following applies: ▪ The child is unable to independently maintain a seated position; ▪ The child has physical anomalies that require support to allow a functional position or prevent further disability; ▪ It is unsafe or the child is unable to sit in a regular chair, commercial highchair, booster chair, or other conventional seat; and/or ▪ The child must be in an upright supported position for safe and effective feeding and without this chair would have to be held by the parent/caregiver for feeding. Activity/positioning chairs with **tilt/recline** features are covered when the above standards are met and at least **one** of the following apply: ▪ The child is unable to maintain head control in an upright seated position; ▪ Requires pressure relief; ▪ Tilt positioning is required to compensate for tonal changes; and/or ▪ Tilt positioning is required for proper feeding/digestion. A **mobile base** may be covered when medically/functionally necessary to move the child to different areas of the home for safety and/or to complete activities of daily living. **Hi-Lo functions** are covered when height adjustments are needed to complete activities of daily living or when needed to assist in transferring into/out of the chair. **Hi-Lo activity/positioning chairs** are covered for children with more severe disabilities requiring maximal support when the above standards are met and at least **one** of the following applies: ▪ Has non-functioning head or trunk control; ▪ Has poor static dynamic seating balance; ▪ Requires varying sitting heights to complete medical/functional activities of daily living; ▪ Positioning cannot be accommodated by use of other mobility devices or commercial products; and/or ▪ Mobility products with interchangeable bases and seating systems have been ruled out as economic alternatives. **Hi-Lo indoor/outdoor base frames** are covered for children who have a wheelchair seating system that can be interchanged with an indoor/outdoor base frame to use as an activity/positioning chair, and it meets the above activity/positioning standards of coverage. The provision of activity/positioning chairs is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/ Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)**

Documentation	Documentation must be less than 180 days old and include **all** the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home. ▪ The MSA-1656 (Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices) and corresponding Addendum B. (Refer to the MSA-1656 Instructions in the Forms Appendix of this Manual.)
PA Requirements	PA is required for all activity/positioning chairs.
Non-Covered	▪ Accessories/add-ons not required for supportive positioning. ▪ Activity/positioning chairs to be used strictly in the school setting. ▪ Back-up or secondary activity/positioning chairs. ▪ Activity/positioning chairs (including feeding chairs) when the child uses a mobility device in the home that has additional positioning accessories.
Payment Rules	Activity/positioning chairs and accessories are **purchase only** items.

2.6.C. STANDERS [CHANGE MADE 4/1/2025]

Definition	A children's stander is a device that supports the child in a standing position for the purpose of weight bearing when the child is unable to stand independently due to a disability or medical condition. Standers can aid in increased bone growth/density, muscle strength, improve digestion, decrease contractures, and prevent pressure ulcers in non-ambulatory children. Types of standers include prone, supine, multi-positional, sit-to-stand, and dynamic standers.
Standards of Coverage	Children's standers are covered for use in the family home when **all** the following apply: ▪ The child is non-ambulatory (without the aid of a mobility device) and unable to stand independently due to a disability or medical condition. ▪ The stander is for use in the child's home (not for use in a school). ▪ The equipment requested can accommodate the child's skeletal alignment. ▪ The child has been trialed in a stander and can use or have the potential to use the stander a minimum of one hour per day (does not have to be a continuous hour). ▪ The child's height and weight meet the manufacturer's product height/weight requirements. The provision of standers is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)**
Documentation	Documentation must be less than 180 days old and include **all** the following: ▪ Diagnosis appropriate for the requested equipment. ▪ Any adaptive or assistive devices currently used in the home. ▪ Outcome of the stander trial(s). ▪ Standing treatment plan (include school standing program, if applicable).

	▪ The MSA-1656 (Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices) and corresponding Addendum B. (Refer to the MSA-1656 Instructions in the Forms Appendix of this Manual.) Additionally, if the child is participating in a school or therapy standing program, submit the current treatment plan including the frequency and duration of standing, the child's standing tolerance, and the make and model of stander used in that setting.
PA Requirements	PA is required for all standers.
Non-Covered	▪ Use of a stander as a mobility device. ▪ A stander for use in school. ▪ Accessories/options not integral to the operation of the stander (e.g., gliders, power lift option, etc.). ▪ A stander for recreational purposes. ▪ A back-up or secondary stander.
Payment Rules	All standers are considered **purchase only** items

2.6.D. GAIT TRAINERS/WALKERS [CHANGE MADE 4/1/2025]

Definition	A **walker** is a mobility device used to assist a child with impaired ambulation who can fully bear weight but needs the support of a walker for safe and independent ambulation. Walkers include, but are not limited to, rigid, wheeled, and folding. A **gait trainer** is a mobility device like a walker but provides more postural support for children with partial weight-bearing capabilities to ambulate independently. Types of gait trainers include upright anterior and posterior support.
Standards of Coverage	Children's **walkers** are covered when **all** the following apply: ▪ The child is unable to ambulate independently due to a disability or medical condition. ▪ The child can functionally weight bear through their legs but requires the support of a walker to safely ambulate. ▪ Other less supportive mobility aids cannot meet the child's medical/functional mobility needs. ▪ The walker is for use in the home and community (where functionally appropriate). Children's **gait trainers** are covered when **all** the following apply: ▪ A children's walker (including a standard front, reverse, or enclosed frame) does not provide enough postural support for the child to safely ambulate. ▪ The child can functionally propel using their legs but requires more postural support than a walker. ▪ The child is unable to ambulate independently due to a disability or medical condition. ▪ The gait trainer is for use in the home and community (where functionally appropriate).

	The provision of gait trainers is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)**
Documentation	Documentation must be less than 180 days old and include **all** the following: ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home and community. ▪ Copy of the school mobility plan (if applicable). ▪ **Gait trainers** require completion of the MSA-1656 (Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices) and corresponding Addendum B. (Refer to the MSA-1656 Instructions in the Forms Appendix of the Manual.)
PA Requirements	PA is required for all children's walkers and gait trainers.
Non-Covered	▪ Multiple pieces of equipment for standing/gait purposes without distinct justification for each item. ▪ Items for pre-mobility development. ▪ Accessories/add-ons not necessary to use the walker or gait trainer or to support positioning. ▪ Back-up walker or gait trainer.
Payment Rules	Walkers and gait trainers are **purchase only** items.

2.6.E. CHILDREN'S BATH/SHOWER/TRANSFER EQUIPMENT

Definitions	Children's bath/shower chairs and transfer equipment are devices that provide seated support to children with disabilities or medical conditions who are unable to or cannot safely sit or stand in a bathtub or shower. Examples of these items include, but are not limited to, bathtub/shower chairs, stools, benches, and bathtub transfer benches. **Standard bath/shower chairs** may be mobile or stationary with a folding or fixed frame, with or without padding, with height adjustable or fixed legs and seat backs, with or without fixed, removable, height-adjustable or drop arms. **Non-standard bath/shower chairs** are like standard bath/shower chairs but include more significant positioning support and/or dual functions for children with more complex needs including, but not limited to, tilt/recline, head/neck/trunk/pelvic supports, footrests, and combination shower/commode chairs. A **standard bathtub or combination bath/commode transfer bench** is a stationary (freestanding with legs or that affixes to the bathtub/wall) seat that sits partially inside the bathtub and extends to the outside of the bathtub to assist the child to transfer in a seated position into the bathtub (some have commode openings or attached commodes). Standard bathtub transfer benches come with or without fixed, adjustable, or removable backs and arm rests, and may come with a commode opening. **Non-standard bathtub or combination bath/commode transfer benches** are like standard transfer benches but include more significant positioning support than standard bathtub or combination bath/commode transfer benches.

Standards of Coverage	**Standard** bath/shower chairs, transfer benches or combination bath/commode chairs are covered for children with a disability or medical condition when **one** or more of the following apply: ▪ The child cannot sit for baths or stand for showers without support; ▪ The child cannot be safely lifted into/out of the bathtub due to size or weight; ▪ The child cannot independently or with the assistance of a caregiver safely transfer into/out of the bathtub or shower without the support of the device and/or ▪ The child's age, weight and height meet the manufacturer's specifications for the device. **Non-standard** bath/shower chairs, transfer benches or combination bath/commode chairs are covered for children with medical conditions when the above standards of coverage are met, and the child has at least **one** of the following: ▪ Has contractures, decreased head/neck/trunk control, and/or abnormal tone requiring additional positional support. ▪ Requires significant assistance to transfer into/out of the bathtub or shower. **Tilt/recline** bath/shower chairs, transfer benches or combination bath/ commode chairs are covered when the above standards of coverage are met, and the child has **one** or more of the following: ▪ Has significant: ➢ contractures, ➢ decreased head/neck/trunk control, and/or ➢ abnormal tone requiring additional positional support; ▪ Requires maximum to total assistance for transfers and bathing; ▪ Cannot sit upright and must be tilted or reclined for safe positioning while bathing; ▪ Has a medical need that requires the tilted or reclined position when upright; and/or ▪ Requires pressure relief while bathing/showering/toileting. The policy standards of coverage for both bath/shower chairs/transfer benches and for commodes must be met when requesting combination bath/shower/commode chairs/transfer benches.
Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis or medical condition related to the need for the equipment. ▪ Current adaptive or assistive devices used for bathing/showering and, if applicable, transferring.
PA Requirements	PA is not required for standard bath/shower chairs or standard bathtub transfer benches or standard combination bathtub/commode transfer benches if the standards of coverage are met. PA is required for non-standard bath/shower chairs/benches, non-standard bathtub transfer benches, non-standard combination bath/commode transfer benches, and tilt/recline shower/commode chairs.

Non-Covered	▪ Hand-held shower attachments or faucet adapters. ▪ Commercial baby bathtubs. ▪ Secondary or back-up bath/shower equipment.
Payment Rules	All bath/shower equipment are purchase only items.

2.6.F. CHILDREN'S/ADOLESCENT COMMODES

Definition	A commode is a chair with an enclosed pan or pail that may be stationary or mobile, with fixed or removable arms, and footrest, or that may be a combination bath/shower commode. **Standard commodes** may be mobile or stationary with a folding or fixed frame, with or without padding, with or without a chest strap, with height-adjustable or fixed legs and seat backs, with or without fixed, removable or drop arms. **Non-standard commodes** are like standard commodes but include more significant positioning support and/or dual functions for children with more complex needs including, but not limited to, the following: tilt/recline, head/neck/trunk/pelvic supports, footrests, and non-standard combination shower/commode chairs.
Standards of Coverage	**Standard** children's size commodes are covered when the child has a disability or temporary injury (see hospital discharge*) and **one** of the following applies: ▪ The child is unable to safely use a conventional toilet; ▪ The child is confined to a single room; ▪ The child is confined to one level of the home that does not have an accessible bathroom; or ▪ The child's age, weight, and height meet the manufacturer's product indications for age appropriateness, weight, and height. Detachable or drop arm commodes may be covered for children requiring transfer assistance. **Non-standard commodes or combination shower/commode chairs** are covered when one of the following applies: ▪ Requires significant assistance to transfer for toileting and/or bathing. ▪ Has contractures, decreased head/neck/trunk control and/or abnormal tone requiring additional positional support. **Tilt/recline shower/commode chairs** are covered when the above criteria and one of the following applies: ▪ Is unable to sit upright with/without support accessories; ▪ Requires tilt or recline positioning for safe bathing; or ▪ Requires pressure relief while sitting for toileting/bathing/showering. The policy standards of coverage for both bath/shower chairs/transfer benches and for commodes must be met when requesting combination bath/shower/commode chairs/transfer benches.

	*Prior authorization is waived for the first three months following hospital discharge for temporary rental of a standard commode. (Refer to the Hospital Discharge Waiver Services subsection of this chapter for additional information.)
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis related to the need for the equipment. ▪ Functional limitations requiring the equipment. ▪ Child's weight and height. ▪ Discharge date from the hospital, if applicable.
PA Requirements	PA is not required for a **standard commode or standard combination bath/ shower/commode chair/transfer bench** for any of the following if the Standards of Coverage are met: ▪ Rental up to three months following hospital discharge. ▪ Purchase or rental of a standard stationary, mobile, commode chair with fixed or detachable arms for the following diagnoses: ➢ Amyotrophic Lateral Sclerosis ➢ Multiple Sclerosis ➢ Cerebral Palsy, Unspecified ➢ Congenital and Progressive Hereditary Muscular Dystrophy ➢ Fracture of Vertebral Column with Spinal Cord Injury (cervical and dorsal) ▪ Replacement of pail or pan for use with commode chair (frequency rules apply). PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Non-standard commodes or non-standard combination shower/commode chairs/transfer benches or tilt/recline shower/commode chairs. ▪ Commodes with footrests and/or seat mechanisms. ▪ Continued coverage after the three-month rental following hospital discharge for a diagnosis not removed from PA. ▪ Replacement is required within two years of purchase.
Non-Covered	▪ Back-up/secondary commodes. ▪ Potty chairs or other potty-training devices.
Payment Rules	**Standard commodes** may be considered a **capped rental or purchase** item. Reimbursement for all **standard** commodes includes the pail/pan and all accessories (except footrest). If the unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

	Non-standard commodes, combination shower/commode and tilt/recline shower/ commode chairs are **purchase only** items and include all accessories necessary to use the commode (except footrests).

2.7 COMMODES

Definition	A commode is a chair with an enclosed pan or pail that may be stationary or mobile, with fixed or removable arms, a seat lift, and footrest.
Standards of Coverage	A **standard commode** may be covered if the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **heavy-duty commode** may be covered for a beneficiary weighing 300 pounds or greater and the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A **shower commode chair** may be covered if required to enable the beneficiary to shower independently or with assistance in the home setting and there are no cost effective alternatives.
Documentation	Documentation must be less than 180 days old and include: ▪ Diagnosis appropriate for the equipment requested. ▪ Functional limitations requiring the equipment. ▪ Weight (if a heavy-duty commode is required). ▪ Discharge date from hospital, if applicable.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: ▪ Up to Three Months Following Hospital Discharge **-** rental of a stationary commode chair with fixed arms (or) stationary commode chair with detachable arms for a diagnosis not already removed from PA. ▪ Purchase or rental of a stationary, mobile, extra wide, or heavy duty commode chair with fixed or detachable arms for the following diagnoses: ➢ Amyotrophic Lateral Sclerosis ➢ Multiple Sclerosis ➢ Cerebral Palsy, Unspecified ➢ Congenital and Progressive Hereditary Muscular Dystrophy ➢ Fracture of Vertebral Column With Spinal Cord Injury (cervical and dorsal) ▪ Replacement of pail or pan for use with commode chair.

	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Commodes with footrests and/or seat mechanisms. ▪ Continued coverage after the three-month rental following hospital discharge for a diagnosis not removed from PA. ▪ Replacement is required within five years if the beneficiary is over 21. ▪ Replacement is required within two years if the beneficiary is under 21.
Payment Rules	A commode may be considered a **capped rental** or **purchase** item. Reimbursement for all commodes includes pail/pan and accessories (except footrest). If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.8 Complex Rehabilitation Technology (CRT) Equipment/Accessories [Subsection Added 4/1/2025]

Pursuant to Public Act 103 and Public Act 104 of 2024, effective January 1, 2025, MDHHS established a CRT equipment/accessories DME benefit by identifying specific Healthcare Common Procedure Coding System (HCPCS) codes as CRT equipment and accessories. Per Public Acts 103 and 104 of 2024, Medicaid fee-for-service (FFS) and Medicaid Health Plans (MHPs) are prohibited from including CRT equipment and accessories into competitive bidding, selective contracting, or similar initiatives.

CRT Definition	CRT equipment is a subcategory of DME that can be individually configured to meet the medical/functional needs of beneficiaries with complex physical or functional limitations (e.g., traumatic brain injury, amyotrophic lateral sclerosis, spina bifida, etc.). CRT equipment includes specialized manual and power wheelchairs with additional options/accessories, adaptive seating and positioning, standing frames, gait trainers, etc. (Refer to the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes list posted on the Medical Suppliers/Orthotists/ Prosthetists/DME Dealers webpage. Refer to the Directory Appendix for website information.) Individually configured means the equipment has various sizes, features, and modifications that a qualified CRT provider can apply specific to the beneficiary by measuring, fitting, programming, adjusting or adapting the equipment consistent with the beneficiary's medical/functional needs as identified by the evaluation of a QHCP.
Standards of Coverage	The provision of CRT equipment and accessories (including repairs to and replacement of) is limited to DME providers who are enrolled with Medicaid as CRT providers. (Refer to the Provider Enrollment subsection and the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for CRT/non-CRT DME provider enrollment information.) Refer to product-specific sections of this chapter for standards of coverage and documentation requirements.

Evaluation	In addition to the documentation and evaluation requirements indicated in the specific DME equipment subsections of this chapter, all CRT equipment requires the complex needs beneficiary to be evaluated by a QHCP. (Refer to the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection for additional information.) A qualified CRT professional must be present at the time of the evaluation. The QHCP must not have a financial relationship with the CRT provider, unless the CRT provider is owned by a hospital and the QHCP is employed by the same hospital to work in the inpatient or outpatient setting. If a CRT professional is not available in the beneficiary's geographic location, the QHCP may perform the evaluation and coordinate provision of the equipment through an MDHHS-authorized non-CRT DME provider.
PA Requirements	All CRT equipment and accessories require PA.
Non-CRT DME Providers	MDHHS may approve a non-CRT DME provider to supply CRT equipment and accessories on a case-by-case basis through PA if an enrolled CRT provider is not available in the beneficiary's geographic location. MDHHS will consider the experience, education and training of the non-CRT DME provider's technician to determine whether the non-CRT DME provider may provide CRT equipment/accessories to individual beneficiaries. ▪ **Delivery of** CRT equipment prior to January 1, 2025: ➢ Non-CRT DME providers may perform repairs to base CRT equipment for the life of the equipment if the provider is the same provider who delivered the original equipment to the beneficiary prior to January 1, 2025. ➢ For future PA repair requests of the base equipment, the non-CRT DME provider must include in the documentation submitted with the PA request the original PA number and the make/brand/model and serial number of the base equipment. ➢ If PA is not required for the part, the non-CRT DME provider must report the original PA number and the make/brand/model and serial number of the base equipment in the claim notes section on direct data entry (DDE) claims or loop/segment 2300/NTE on the ASC X12N 837P 5010 electronic claim. ▪ **PA of** CRT equipment prior to January 1, 2025: ➢ Non-CRT DME providers who received PA approval for CRT base equipment and accessories with an authorization start date before January 1, 2025, may supply the approved equipment if it is delivered to the beneficiary within six months of the authorization period start date. Repairs to this equipment may be performed by the non-CRT DME provider for the life of the base equipment. Refer to the above repair instructions for CRT base equipment provided prior to January 1, 2025. **(text added per bulletin MMP 24-58)**

2.9 Compressor (Large Volume) [Re-numbered 4/1/2025]

Definition	A compressor is an electrical device that provides humidity to a tracheostomy and is capable of continuous operation.
Standards of Coverage	A compressor is covered to provide humidity for a tracheostomy.

Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/medical condition related to the need for the equipment. ▪ Specific unit requested.
PA Requirements	PA is not required for rental of a large volume compressor if the Standards of Coverage are met and documentation details one of the following diagnoses: ▪ Artificial Opening Status – Tracheostomy ▪ Attention to Artificial Openings – Tracheostomy
	PA is required for: ▪ Purchase of a large volume compressor (if not rented for 10 months). ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years.
Payment Rules	A unit may be considered a **capped rental** item or **purchased** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.10 CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE [RE-NUMBERED 4/1/2025]

Definition	The continuous positive airway pressure (CPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts.
Standards of Coverage	A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: ▪ Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or ▪ AHI documents 5 to 14 events per hour with related symptoms such as: ➢ Excessive daytime sleepiness, impaired cognition, mood disorders; and/or ➢ Hypertension, ischemic heart disease, or history of stroke, or morbid obesity. For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.

Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition related to the need for the CPAP device. ▪ A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep. ▪ For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted. ▪ Prescription from an appropriate pediatric subspecialist is required **for coverage under the CSHCS Program.**
PA Requirements	PA is not required if the Standards of Coverage are met and: ▪ The beneficiary is over the age of 21 and has one of the following diagnoses: ➢ Obstructive Sleep Apnea (Adults) ➢ Tracheostomy Complications ➢ Tracheomalacia ➢ Other Anomalies of Larynx, Trachea, and Bronchus ➢ Insomnia with Sleep Apnea ➢ Hypersomnia with Sleep Apnea ➢ Other and Unspecified Sleep Apnea ▪ For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea. ▪ The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years. PA is given for the initial four months and then for the final six months.
Payment Rules	A CPAP device is considered a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPAP mask should be considered prior to replacement of the entire mask.)

2.11 Diabetic Equipment and Related Supplies [Re-numbered 4/1/2025]

2.11.A. Blood Glucose Monitoring Equipment and Supplies [Re-numbered 4/1/2025]

Definition	Blood glucose monitoring supplies and equipment are defined as those items necessary to monitor blood glucose levels. The equipment and supplies include, but are not limited to, blood glucose monitors, testing strips, lancets, and calibrator solution/chips.
Standards of Coverage	A home blood glucose monitor and related supplies are covered when a beneficiary has been diagnosed with diabetes and it is medically necessary to monitor fluctuations of blood glucose levels on a daily basis. Diabetes includes: ▪ Gestational diabetes ▪ Insulin-treated diabetes ▪ Non-insulin treated diabetes Diabetes medications (i.e., metformin, Januvia, etc.) do not qualify as insulin treatment. Quantity limits for lancets, blood glucose test strips/reagent test strips, and urine test/reagent strips/tablets are based upon insulin-treated or non-insulin-treated diabetes. Refer to the Medicaid Code and Rate Reference tool in CHAMPS for quantity and frequency information. (Refer to the Directory Appendix for website information.)
Documentation	Documentation must be less than 90 days old and include all of the following: ▪ Diagnosis/condition related to the need for the blood glucose monitoring. ▪ Items to be dispensed. ▪ Quantity of items to be dispensed for 30 days usage. ▪ Frequency of testing. ▪ For beneficiaries under 21, treatment plan for treating abnormal blood glucose levels (if pediatric endocrinologist did not order the monitor/supplies). ▪ **For CSHCS beneficiaries**, a prescription from a Pediatric Endocrinologist is required. For beneficiaries 21 years of age and older with medical need to test blood glucose more frequently than established quantity limits, the physician must indicate the medical need and duration ("PRN" or "as needed" is not sufficient documentation to support medical need) for the additional quantities.

PA Requirements	PA is not required when the Standards of Coverage are met and the beneficiary has one of following diagnoses: ▪ Diabetes Mellitus Without Mention of Complications ▪ Diabetes with Ketoacidosis ▪ Diabetes with Hyperosmolarity ▪ Diabetes with Other Coma ▪ Diabetes with Renal Manifestations ▪ Diabetes with Ophthalmic Manifestations ▪ Diabetes with Neurological Manifestations ▪ Diabetes with Peripheral Circulatory Disorders ▪ Diabetes with Other Specified Manifestations ▪ Diabetes with Unspecified Complications ▪ Diabetes Mellitus Complicating Pregnancy ▪ Abnormal Glucose Tolerance (Gestational Diabetes Only) In addition to the above, PA will not be required if physician documentation substantiates the medical need for an adult (insulin or non-insulin treated) to test more frequently than standardized MDHHS limits. For such circumstances, the provider must append the KX modifier to the A4253 and to the A4259 on the claim. (Refer to the Medicaid Code and Rate Reference tool for quantity limits when using modifier KX with lancets and test strips.)
	PA is required for: ▪ Home blood glucose monitors with special features such as voice synthesis. ▪ Medical need not within the Standards of Coverage if it exceeds quantity limits and/or a diagnosis that has not been removed from PA. ▪ Replacement within three years.
Payment Rules	All items (including the monitor) are considered **purchase only** items. To report date of service (DOS) for blood glucose test or reagent strips, lancets, and normal, low and high calibrator solution, use a span date in the "From" and "To" fields, not to exceed 90 days.

2.11.B. CONTINUOUS GLUCOSE MONITORING EQUIPMENT AND SUPPLIES [RE-NUMBERED 4/1/2025]

Definition	Continuous glucose monitoring systems (CGMS) are devices that measure glucose levels taken from interstitial fluid continually throughout the day and night, providing real-time data to the beneficiary or physician. The CGMS is comprised of three parts: 1) A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels), 2) The transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor), and 3) A receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low).

	CGMS may be non-adjunctive/therapeutic (CGMS can be used to make treatment decisions without the need to confirm test results using a blood glucose monitor [BGM]); or adjunctive/non-therapeutic (beneficiary must use a BGM to test the results displayed on the CGMS prior to making a treatment decision).
Standards of Coverage	A personal use CGMS and supplies are covered for persons with diabetes when all the following are met: ▪ The beneficiary is under the care of one of the following: ➢ An endocrinologist; or ➢ A physician or non-physician practitioner (nurse practitioner, physician assistant or clinical nurse specialist) who is managing the beneficiary's diabetes. ▪ The beneficiary has diabetes requiring the administering of insulin or is currently using an insulin pump. ▪ The beneficiary or their caregiver is educated on the use of the device and is willing and able to use the CGMS. **Note:** CGMS reduce the frequency of fingerstick blood glucose testing but do not eliminate the need to fingerstick test entirely. Glucometers and testing supplies must be made available. These supplies are billed separately (following frequency rules) for adjunctive/non-therapeutic CGMS. Glucometers and testing supplies are included in the monthly supply HCPCS code for non-adjunctive/therapeutic CGMS. Refer to the Payment Rules section of this policy. Although not required for coverage consideration, physicians/non-physician practitioners are encouraged to refer patients who are willing and able to attend a certified diabetes self-management education training program. A map identifying Medicaid enrolled diabetes self-management education and support (DSME) providers can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

Documentation	Documentation must be less than 90 days old and include all the following: ▪ A written order by the treating physician/non-physician practitioner; ▪ Diagnosis related to the need for the CGMS; ▪ Length of need; ▪ Frequency of insulin administered per day or if the beneficiary is using an insulin pump; ▪ Records of hypoglycemic events, HbA1c levels, uncontrolled ketoacidosis, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable; and ▪ Current treatment plan. The initial order must be written for six months. If the beneficiary continues to utilize the CGMS, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters, receivers and other separately billed supplies used with the CGMS (following frequency rules) may be written for a 12-month period. **Note:** Children's Special Heath Care Services (CSHCS) beneficiaries require a prescription from a CSHCS authorized physician subspecialist. Refer to the Children's Special Health Care Services chapter for additional information.
PA Requirements	Prior authorization is not required for the following if standards of coverage and documentation requirements are met. ▪ Type I diabetes. ▪ Infants and toddlers (age 5 and under*). ▪ Diabetes in pregnancy, childbirth, and the puerperium period (insulin or non-insulin treated). *It is assumed that hypoglycemic unawareness is common within this age group. Prior authorization is required for all other conditions and clinical scenarios where use of CGMS may be beneficial, including but not limited to, Type II diabetes.
External Insulin Pump Combined with CGMSs	An external insulin pump combined with a CGMS is covered when the external insulin pump and the CGMS policy standards of coverage are met. To be considered for coverage, the device must be approved by the Food and Drug Administration (FDA) as a combined insulin pump/CGMS.
Non-Covered	Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered by Medicaid.

Payment Rules	The sensor, transmitter and receiver are purchase-only items, except for Healthcare Common Procedure Coding System (HCPCS) codes E2102 and E2103 may be purchased, rented or used item). Adjunctive/non-therapeutic CGMS (E2102) require the beneficiary to use a BGM to test the results shown on the CGMS prior to making a treatment decision. The BGM and BGM supplies are not included in the allowance for the adjunctive/non-therapeutic CGMS supply (A4238) and may be billed separately (within BGM policy limits). HCPCS code A4238 is comprised of all items necessary to use the device (E2102), including CGMS sensors and transmitters. The following HCPCS codes are included in the allowance for A4239 and may not be billed separately: A4233, A4234, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100 and E2101. The product warranty must be expired prior to replacement of the transmitter and/or receiver. Providers must use the most appropriate HCPCS code for each brand/make/model of CGMS by reviewing the Food and Drug Administration (FDA) product approvals and the Pricing, Data Analysis and Coding (PDAC) contractor website for coding assignment. Upcoding a product to receive higher reimbursement is incorrect billing and could result in post-payment recovery of funds or provider audit. Refer to the Medicaid Code and Rate Reference tool for HCPCS code coverage parameters.

2.11.C. External Infusion (Insulin) Pump and Supplies [Re-numbered 4/1/2025]

Definition	Insulin pumps deliver a constant and continuous infusion of insulin, driven by mechanical force, into the subcutaneous space via a needle or soft cannula.
Standards of Coverage	Insulin pumps are covered when other methods to control blood glucose levels have been ineffective and one of the following applies: ▪ Blood glucose levels demonstrate poor glycemic control despite monitoring at least four times per day and multiple daily insulin injections with a persistently elevated glycosylated hemoglobin level greater than seven percent. ▪ There is a history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reaction, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements. ▪ There is evidence of the "dawn" phenomenon where fasting blood glucose level often exceeds 200 mg/dl.

Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis/medical condition pertaining to the need for the pump. ▪ Lab values of blood glucose levels. ▪ Medical history documenting the need for the pump. ▪ Any medical complications experienced by the beneficiary related to the need for blood glucose monitoring. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.
PA Requirements	PA is not required if the Standards of Coverage are met, and: ▪ The beneficiary is over the age of 16 and has one of the diagnoses indicated below: ➢ Diabetes Mellitus without Complication ➢ Diabetes with Ketoacidosis ➢ Diabetes with Hyperosmolarity ➢ Diabetes with Other Coma ➢ Diabetes with Renal Manifestations ➢ Diabetes with Ophthalmic Manifestations ➢ Diabetes with Neurological Manifestations ➢ Diabetes with Peripheral Circulatory Disorders ➢ Diabetes with Other Specified Manifestations ➢ Diabetes with Unspecified Complication ➢ Diabetes Mellitus Complicating Pregnancy ▪ The beneficiary is under the age of 16, has one of the diagnoses above, and the pump is ordered by a pediatric endocrinologist.
	PA is required for the following: ▪ Medical need beyond the Standards of Coverage. ▪ Diagnoses/conditions other than those listed above. ▪ Replacement of pump within five years.
Payment Rules	Insulin pumps are considered a **purchase only** item**.** The purchase payment is inclusive and includes all of the following: ▪ A 30-day trial period at no cost to Medicaid or the beneficiary prior to purchase of device. ▪ Comprehensive care coordination, including a plan for follow-up monitoring by the physician after installation of the pump.

2.12 Diabetic Shoes and Inserts [Re-numbered 4/1/2025]

Definition	Diabetic shoes, inserts and related modifications include, but are not limited to, depth inlay shoes, multi-density inserts, roller or rocker bottoms, wedges, metatarsal bar, and offset heel.
Standards of Coverage	Diabetic shoes, inserts, and/or modifications may be covered for individuals who have, due to complications with diabetes mellitus, one of the following conditions: ▪ History of previous foot ulcerations or pre-ulcerative calluses. ▪ Established peripheral neuropathy or sensory impairment. ▪ Peripheral Vascular Disease with an ankle brachial index at rest of 0.5 or less following exercise. ▪ Loss of a toe or portion of the foot due to amputation arising from diabetes. A **custom-molded diabetic shoe** is covered only if the depth shoe cannot accommodate a foot anomaly. **Inserts** are covered if the beneficiary requires a depth shoe or custom-molded diabetic shoe. For a depth shoe, three inserts would be separately reimbursable in addition to the noncustomized one included with the shoe. For a custom-molded shoe, two inserts would be separately reimbursable. Modifications to a custom-molded or depth shoe may be covered rather than an additional insert.
Documentation	Documentation must be less than 30 days old and include all of the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification.
PA Requirements	PA is not required for the following inserts if the Standards of Coverage are met: ▪ Multiple density insert, direct formed, molded to foot with external heat source. ▪ Multiple density insert, direct formed, compression molded to patient's foot without external heat source. ▪ Multiple density insert, custom fabricated and custom-molded from model of patient's foot. ▪ Depth inlay shoes. ▪ Modifications if an additional insert is not provided.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within one year. ▪ Quantity beyond established limits. ▪ Custom-fabricated shoes and other inserts not included above.
Payment Rules	All items are considered **purchase only**.

2.13 Enclosed Bed Systems [Re-numbered 4/1/2025]

Definition	An Enclosed Bed System includes the mattress, bed frame, and enclosure as one unit.
Standards of Coverage	An Enclosed Bed System may be covered if the following applies: ▪ There is a diagnosis/medical condition (e.g., seizure activity) which could result in injury in a standard bed, crib, or hospital bed; and ▪ There are no economic alternatives to adequately meet the beneficiary's needs.
Documentation	The documentation must be less than six months old and include: ▪ Diagnosis/medical condition requiring use of the bed and any special features (if applicable). ▪ Safety issues resulting from the medical condition and related to the need for an Enclosed Bed System. ▪ Other products or safety methods already tried without success (e.g., bumper pads/rails). ▪ Type of bed requested. ▪ Type of special features requested, if applicable.
Noncovered Conditions	Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc.
PA Requirements	PA is required for all Enclosed Bed Systems.
Payment Rules	The Enclosed Bed System is considered a **purchase only** item. For Youth Beds, refer to the Hospital Beds subsection of this chapter.

2.14 Enteral Nutrition [Re-numbered 4/1/2025]

Enteral nutrition is nutrition administered by tube or orally into the gastrointestinal tract. Enteral nutrition is classified into categories that possess similar characteristics. Categories for enteral nutrition are listed by HCPCS codes on the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule on the MDHHS website. For the appropriate HCPCS code, products are listed on the enteral nutrition product classification list on the website for the Medicare Pricing, Data Analysis and Coding (PDAC) contractor. If the formula is not listed in the covered HCPCS codes, the provider must contact the PDAC contractor for a coding determination. (Refer to the Directory Appendix for website and contact information.)

2.14.A. Enteral Nutrition (Administered Orally) [Re-numbered 4/1/2025]

Standards of Coverage	Enteral nutrition (administered orally) may be covered for beneficiaries **under the age of 21** when: ▪ A chronic medical condition exists resulting in nutritional deficiencies, and a three-month trial is required to prevent gastric tube placement; or ▪ Supplementation to regular diet or meal replacement is required, and the beneficiary's weight-to-height ratio has fallen below the fifth percentile on standard growth grids; or ▪ Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition. **For CSHCS coverage**, a nutritionist or appropriate pediatric subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development. For Healthcare Common Procedure Coding System (HCPCS) code B4162, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD). For beneficiaries **age 21 and over**: ▪ The beneficiary must have a medical condition that requires the unique composition of the formula nutrients that the beneficiary is unable to obtain from food; or ▪ The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/medical condition; or ▪ The beneficiary has experienced significant weight loss. For Healthcare Common Procedure Coding System (HCPCS) code B4157, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD).

Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition related to the beneficiary's inability to take or eat food. ▪ Duration of need. ▪ Amount of calories needed per day. ▪ Current height and weight, as well as change over time. (For beneficiaries under 21, weight-to-height ratio.) ▪ Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts. ▪ List of economic alternatives that have been tried. ▪ The ordering practitioner or practitioner's designated clinical staff (e.g., dietitian, registered nurse, or other appropriate hospital clinical staff) completed BPHASA-2401 Medical Justification for Enteral Therapy form. (Refer to the Forms Appendix of this manual for a copy of the form.) For continued use beyond 3-6 months, **the CSHCS Program requires** a report from a nutritionist or appropriate pediatric subspecialist.
PA Requirements	PA is required for all enteral formula for oral administration. For emergency prior authorization of initial orders for beneficiaries discharging from the inpatient hospital setting, the medical supplier may call the Program Review Division to request a verbal authorization. (Refer to the Directory Appendix for contact information.)

2.14.B. Enteral Nutrition (Administered by Tube) [Re-numbered 4/1/2025]

Standards of Coverage	Enteral formula are covered when the diagnosis/medical condition requires placement of a gastric tube and nutrition is administered by syringe, gravity, or pump.
Documentation	Documentation must be less than 30 days old and include: ▪ Specific diagnosis/medical condition requiring tube feeding. ▪ Duration of treatment. ▪ Amount needed per day. ▪ If a pump is required, the medical reason why syringe or gravity method could not be used. ▪ The ordering practitioner or practitioner's designated clinical staff (e.g., dietitian, registered nurse, or other appropriate hospital clinical staff) completed BPHASA-2401 Medical Justification for Enteral Therapy form. (Refer to the Forms Appendix of this manual for a copy of the form.)
PA Requirements	PA is not required for standard formula for enteral tube feedings provided up to the program's established quantity limits per month. (Applies only to specific enteral formula and related supplies and equipment. Refer to the Medicaid Code and Rate Reference tool for additional information.)
	PA is required for the following: ▪ All specialized enteral formula requests for tube feedings.

	▪ Over-quantity requests for standard formula enteral tube feedings. ▪ Medical need beyond Standards of Coverage. For emergency prior authorization of initial orders for beneficiaries discharging from the inpatient hospital setting, the medical supplier may call the Program Review Division to request a verbal authorization. (Refer to the Directory Appendix for contact information.)

2.14.C. Enteral Nutrition Payment Rules [Re-numbered 4/1/2025]

When billing for enteral formula (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. (To calculate the appropriate number of caloric units, combine total calories of all cans to be used and divide by 100.) Medicaid will reimburse for a maximum quantity of up to 900 units for any combination of approved formula.

Providers should refer to the following chart for additional assistance:

Formula	100 calories = 1 unit (u)	6 (8 oz) cans a day	1 month = 30 days	6 months = 180 days	$5.00 cost/8 oz liquid or packet or can
Standard @ 250 calories/8 oz	250 cals/100 =2.5 units	2.5 u x 6 = 15 units a day	15 u x 30 = 450 units a month	15 u x 180=2700 units for 6 months	$5.00 ÷ 2.5 u = $2.00 per unit
Caloric Dense @ 355 calories/8 oz	355 cals/100 =3.55 units	3.55 u x 6= 21 units a day	21 u x 30 = 630 units a month	21 u x 180 = 3780 units for 6 months	$5.00 ÷ 3.55 u = $1.41 per unit
Powder, 1 package = 150 calories	150 cals/ 100 = 1.5 units	1.5 u x 6 = 9 units a day	9 u x 30 = 270 units a month	9 u x 180 =1620 units for 6 months	$5.00 ÷ 1.5 u = $3.33 per unit
Powder, 1# can = 112 oz when mixed @ 20 calories/oz* = 2240 calories for the entire can (*can vary with physician orders)	2240 cals/100 = 22.4 units		6 cans per month = 22.4 u x 6 = 134 units a month	134 u x 6 months = 804 units for 6 months	$5.00 ÷ 22.4 u = $0.30 per unit

The necessary equipment and supply code for enteral tube feedings should be billed up to specified quantity limits. Feeding bags, anchoring devices, syringes, drain sponges, cotton tip applicators, tape, adaptors, and connectors used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit codes and should not be billed separately.

Dietary formula for oral feedings may be obtained from either a medical supplier or a pharmacy.

Dietary formula for tube feedings are covered only through the medical supplier.

2.15 High Frequency Chest Wall Oscillation Device [Re-numbered 4/1/2025]

Definition	A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mobilization, and facilitates it along toward central airways.
Standards of Coverage	An HFCWO device may be covered up to four months for the following when all other treatment modalities have not been effective (e.g., chest physiotherapy, medication, mechanical in-exsufflation device, etc.): ▪ Cystic Fibrosis (CF) ▪ Bronchiectasis that has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by: ➢ Daily productive cough for at least six continuous months; or ➢ Frequent (i.e., more than two per year) exacerbations requiring antibiotic therapy. ▪ Neuromuscular and/or neurological disorders affecting ability to mobilize secretions (e.g., muscular dystrophy, spastic quadriplegic cerebral palsy, spinal muscular atrophy, quadriplegia, etc.) Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet the policy standards of coverage criteria.
Documentation	Submitted documentation must be from a Neurology, Physical Medicine & Rehabilitation, or a Pulmonology practitioner. Documentation must be less than 180 days old and include: ▪ Diagnosis pertaining to the need for the HFCWO device. ▪ Severity of condition (e.g., frequency of hospitalizations, pulmonary function tests, etc.). ▪ Current treatment modalities and others already tried, including why those treatments did not meet the beneficiary's medical need. ▪ Plan of care by the authorized physician subspecialist substantiating need for the device is **required under the CSHCS Program**. ▪ For continuation beyond the initial four months, the following information must be provided: ➢ Documentation of any change in the prescribed treatment plan; ➢ Documentation from equipment use logs (includes a meter that measures daily use; a cumulative hours meter does not meet this requirement) demonstrating ongoing utilization in accordance with the current, prescribed treatment plan; and ➢ For CSHCS beneficiaries, the CSHCS program requires a medical statement from the authorized physician subspecialist substantiating the continued effectiveness of the vest.

PA Requirements	PA is not required for the diagnosis of cystic fibrosis (CF) if the standards of coverage are met. PA is required for: ▪ All other medical conditions. ▪ Replacement of the device or accessories (e.g., vest, hose, etc.). ▪ Repairs to the device. Although PA is not required for CF beneficiaries when the standards of coverage are met, all required documentation indicated above and in the MDHHS Medicaid Provider Manual must be kept in the beneficiary's file and be available upon request. Failure to keep required documentation in the beneficiary's file may result in provider audit and/or post-payment recovery of funds.
Payment Rules	The HFCWO device is considered a capped rental item and is inclusive of the following during the rental period: ▪ All accessories necessary to use the equipment (hoses, vest, electrical components, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs and replacements to make the equipment functional. For purchased items, the manufacturer's warranty must be exhausted prior to requesting a repair to the device or for replacement of the device or part(s).

2.16 HOME INTRAVENOUS INFUSION THERAPY [RE-NUMBERED 4/1/2025]

Definition	Intravenous infusion therapy, administered in the home, is medicine injected directly into a vein.
Standards of Coverage	Coverage of home infusion therapy, its expected course, and duration of treatment is based on the plan of care prescribed by the physician. Only the days involving active infusion will be considered for payment. The medical supplier facilitating the administration of home infusion therapy must: ▪ Be accredited through The Joint Commission or other appropriate accrediting body. ▪ Maintain logs detailing proper equipment maintenance consistent with manufacturer's requirements. ▪ Provide education and training to the beneficiary or caregiver related to proper care techniques. ▪ Provide comprehensive care coordination involving the pharmacist, nurses, physician or any other infusion therapy professional.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis appropriate for specified therapy ▪ Dosage, frequency, route and duration of medication(s) being infused

	Documentation for **antibiotic, antiviral and/or antifungal therapies** must include at least one of the following tests results to support the diagnosis: ▪ Positive culture from appropriate site (e.g., a blood culture for diagnosis of sepsis, wound culture for diagnosis osteomyelitis, etc.) ▪ Bone scan showing osteomyelitis ▪ X-ray showing osteomyelitis or abscess ECHO/ultrasound showing endocarditis ▪ Vegetations or abscess ▪ CT or MRI scan showing osteomyelitis or abscess ▪ Minimum of three of the following: ➢ Fever of 101° F or more, pain, warmth, redness, edema in affected area ➢ Elevated C-reactive protein ➢ Elevated white blood cell count ➢ Elevated erythrocyte sedimentation rate (ESR) ➢ A trial course of oral antibiotic therapy with no improvement or worsening of symptoms ▪ For the diagnoses of cellulitis, pneumonia, urinary tract infection, and otitis media, documentation must indicate a failure of oral antibiotic therapy, unless a culture shows bacteria that is not sensitive to oral antibiotic medications available. This does not apply to cystic fibrosis pneumonia; PA is not needed with a positive sputum culture or a history of positive sputum cultures.
	Documentation for **electrolyte replacement therapy (condition unrelated to hydration status)** must include a copy of the appropriate abnormal laboratory level (e.g., low potassium level for diagnosis hypokalemia, etc.).
	Documentation for **steroid therapy** must indicate exacerbation of multiple sclerosis or diagnosis related to transplant rejections.
	Documentation for **chemotherapy and pain management therapy** must include a cancer diagnosis and a copy of the treatment protocol to which the beneficiary has been assigned.
	Documentation for **hydration therapy for hyperemesis gravidarium** must include laboratory results indicating current dehydration level, estimated delivery date, and must address a trial of anti-emetics.
	Documentation for **gammaglobulin therapy** must include abnormal IGG, IGM, IGA or IGE levels prior to the beneficiary receiving an IVIG. If beneficiary has been receiving IVIG infusion therapy in an outpatient or physician office setting, these laboratory tests may not be current.
	Documentation for **iron overload therapy** must indicate a diagnosis of Sickle Cell Anemia and support the need for the requested therapy.
	Documentation for **factor products** must indicate a clotting disorder diagnosis and support the need for requested therapy.
	Documentation for **anti-emetic infusion** must indicate a diagnosis of cancer or hyperemesis gravidarum and include a trial of oral anti-emetics.

<table>
<tr><td></td><td>The provider must keep verification of equipment maintenance on file that includes:
Name of the manufacturer
Dates the equipment was checked for proper use, care and function according to the manufacturer's requirements</td></tr>
<tr><td rowspan="2">PA Requirements</td><td>PA is not required for specific HCPCS "S" codes if all of the following apply:
Standards of Coverage are met
Beneficiary is age five or older (for factor products, beneficiaries of all ages)
Medical need for the therapy is related to one of the diagnoses/conditions that do not require PA. (For details regarding covered HCPCS "S" codes, PA requirements and related ICD diagnosis exception code ranges, and quantity limits, refer to the Medicaid Code and Rate Reference tool.)</td></tr>
<tr><td>PA is required for the following:
Medical need beyond the Standards of Coverage.
The beneficiary is under the age of five.
Infusion days exceed the established Medicaid limits.
When PA is required, the following HCPCS codes are authorized via a telephone authorization process:<table><tr><td>S5498</td><td>S5501</td><td>S5502</td><td>S5520</td></tr><tr><td>S5521</td><td>S9326</td><td>S9327</td><td>S9330</td></tr><tr><td>S9331</td><td>S9338</td><td>S9345</td><td>S9346</td></tr><tr><td>S9348</td><td>S9351</td><td>S9355</td><td>S9374</td></tr><tr><td>S9375</td><td>S9376</td><td>S9377</td><td>S9379</td></tr><tr><td>S9490</td><td>S9497</td><td>S9500</td><td>S9501</td></tr><tr><td>S9502</td><td>S9503</td><td>S9504</td><td>S9537</td></tr></table>Refer to the Directory Appendix for MDHHS Program Review Division telephone prior authorization of specified DME and medical supplies information.</td></tr>
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Payment Rules	Reimbursement for the HCPCS "S" codes related to home intravenous infusion therapy is calculated on a per diem basis as defined by the code descriptions. Costs included within the per diem rate: ▪ All infusion related supplies and equipment, such as the infusion pump, needles, syringes, gauze, sterile tubing, catheters, etc. (For pump-related infusion, the per diem rate payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional.) ▪ The compounding of medications compliant with standards of pharmaceutical practice, including a medication profile set-up with recommendations of dosage or medication changes if needed. ▪ Patient educational activities related to receiving home infusion therapy and the coordination of care with physicians, nurses and other caregivers. Costs not associated with the per diem rate: ▪ Medications (drugs) must be billed as pharmacy services. ▪ Nursing visits are covered through a Home Health Agency. ▪ PICC and Midline insertion procedures and associated supplies may be billed separately. **HCPCS "S" codes** must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted. Routine catheter care is included within the daily rate for the active infusion. For interim maintenance of an infusion line not currently in use, report the appropriate catheter care code and bill as a daily rate by reporting the total number of days used as units. For catheter maintenance of an implanted port, bill the appropriate HCPCS code with modifier "22". Details regarding the type and frequency of catheter maintenance completed must be reported in the Remarks area of the claim. If multiple drugs are being administered concurrently for the same therapy, report modifier "SH" for two drugs or "SJ" for three or more drugs. If multiple therapies are needed, more than one therapy code may be reported. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral, or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service. If multiple drugs are administered, report modifier "SH" or "SJ". With the administration of Medicare Part D drug(s) to dual eligibles (Medicaid/ Medicare), report the appropriate HCPCS "S" code for medical supplies and/or equipment (e.g., IV poles, tubing) associated with home intravenous infusion therapy. For dual eligibles residing in a nursing facility, the equipment and supplies are part of the facility's per diem rate.

2.17 Home Uterine Activity Monitor [Re-numbered 4/1/2025]

Definition	A home uterine activity monitor (HUAM) is used to record the frequency of uterine contractions for the purpose of predicting pre-term delivery. The monitor is worn on a belt and records the uterine contractions that are transmitted across modem lines to a central monitoring office that contacts the physician's office for interpretation.
Standards of Coverage	A HUAM may be covered for up to 90 days in the home setting for a beneficiary at high risk for pre-term delivery during the 24th through the 36th gestational week, and one of the following medical conditions applies: ▪ Pre-term labor on tocolytics. ▪ History of pre-term labor or delivery in previous pregnancies. ▪ Incompetent cervix (cerclage).
Documentation	Documentation must be less than 90 days old and include: ▪ Diagnosis and/or medical condition pertaining to the need for the monitor. ▪ Expected date of birth. ▪ Last day of the 36th week of gestation. ▪ Involvement with a regional perinatal center.
PA Requirements	PA is required for all monitors. HCPCS code S9001 requires authorization via a telephone prior authorization process. (Refer to the Directory Appendix for MDHHS Program Review Division telephone prior authorization of specified DME and medical supplies information.)
Payment Rules	A HUAM is a **rental only** item and is inclusive of the following: ▪ The monitor and other related supplies required to use the equipment properly. ▪ Education on proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading and interpretation of the data. ▪ Perinatal nursing services related to oversight of the use of the monitor. To provide a HUAM, the medical supplier must complete the CHAMPS Provider Enrollment (PE) on-line application process, selecting a subspecialty of Home Uterine Monitor. (Refer to the Directory Appendix for CHAMPS PE information.)

2.18 Hospital Beds [Re-numbered 4/1/2025]

Definition	A hospital bed has a special construction, consisting of a frame and an innerspring mattress, with a head and/or leg elevation adjustment mechanism for the purpose of repositioning.
Standards of Coverage	A standard hospital bed may be covered if: ▪ The diagnosis/medical condition requires a specific elevation or positioning of the body not possible with a standard bed (elevation of 30 degrees or greater). ▪ The body requires positioning in a hospital bed to alleviate pain. For other beds, the above Standards of Coverage must be met, and one of the following applies: ▪ **Variable height hospital bed** may be covered if different heights are medically necessary for assisting beneficiary transfers from the chair, wheelchair or standing position. ▪ **Heavy-duty extra-wide hospital bed** may be covered if a beneficiary weighs more than 350 pounds but does not exceed 600 pounds. ▪ **Extra heavy-duty bed** may be covered if a beneficiary weighs more than 600 pounds. ▪ A **fully electric hospital bed** may be covered when frequent and/or immediate changes in body position are required and there is no caregiver. ▪ A **Youth bed** may be covered if the beneficiary is under the age of 21 and the bed is required to have crib style side rails.
	Hospital Bed Accessories ▪ The **trapeze bar** may be covered when required by the beneficiary to assist with transfers or frequent changes in body position. ▪ **Side rails** are covered when required for safety. ▪ A **replacement innerspring** mattress or foam rubber mattress may be covered for replacement when the beneficiary owns the bed.
Noncovered Condition	Youth beds are not covered for the sole purpose of age appropriateness.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical and/or functional reasons for the specific type of hospital bed and/or accessory. ▪ Any alternatives tried or ruled out.

PA Requirements	PA is not required if the Standards of Coverage are met and the following applies: ▪ For fixed height, variable height, semi-electric beds, side rail, and trapeze for one of the following diagnoses/medical conditions: ➢ Multiple Sclerosis ➢ Infantile Cerebral Palsy ➢ Congenital or Hereditary Progressive Muscular Dystrophy ➢ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ Procedure codes E0255, E0256, E0260, E0292, E0293, E0910, E0940 up to three months for hospital discharge when required for diagnoses not removed from PA.
	PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ Full electric beds or any other hospital beds and/or accessories requiring PA as specified in the Medicaid Code and Rate Reference tool. ▪ Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within five years.
Payment Rules	A bed may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment except for trapezes, side rails, and mattresses where appropriate. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.19 INCONTINENT SUPPLIES [RE-NUMBERED 4/1/2025]

Definition	Incontinent supplies are items used to assist individuals with the inability to control excretory functions. The type of coverage for incontinent supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate: ▪ Independent care of bodily functions through proper toilet training. ▪ Appropriate self-catheter care to decrease risk of urinary infections and/or avoid bladder distention. ▪ Proper techniques related to routine bowel evacuation.

Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries)	**Diapers, incontinent pants, liners, and belted/unbelted undergarments without sides** are covered for individuals age three or older if both of the following applies: ▪ A medical condition resulting in incontinence and there is no response to a bowel/bladder training program. ▪ The medical condition being treated results in incontinence, and beneficiary would not benefit from or has failed a bowel/bladder training program.
	Pull-on Briefs are primarily considered a short-term transitional product for beneficiaries with a medical condition causing incontinence of bowel and/or bladder. **<u>Pull-on brief coverage for ages 3 through 20:</u>** Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and one of the following applies: ▪ **For short term use:** The beneficiary is actively participating in a bowel/bladder training plan and is demonstrating consistent measurable progress in the plan (i.e., consistent reduction in the amount of pull-on briefs used, successful completion of the bowel/bladder training in three years or less, etc.); **or** ▪ **For long term use:** The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence; however, the beneficiary has the cognitive and physical ability to care for their toileting needs independently or with minimal assistance. **Bowel/Bladder Training Plan** A bowel/bladder training plan must be designed and implemented within the school and home environments in order to achieve optimum success. **Initial Nursing Assessment and Reassessment** The use of pull-on briefs requires an initial nursing assessment and reassessment every six months thereafter or a time determined by the Michigan Department of Health and Human Services (MDHHS). Reassessments must detail measurable progress the beneficiary has made in the training plan since the last assessment. Long-term use requires an initial nursing assessment and reassessment every 24 months thereafter or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file. If the beneficiary no longer has a medical condition causing bowel/bladder incontinence and they have not achieved continence within three years of the start of the bowel/bladder training program, the pull-on briefs will no longer be a covered benefit. **Pull-on brief coverage for ages 21 and older:** Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and the beneficiary is able to care for their toileting needs independently or with minimal assistance from a caregiver and one of the following applies: ▪ **For short term use:** The beneficiary has a temporary medical condition (including recent discharge from a nursing home or hospital) causing bowel/bladder incontinence; **or**

	▪ **For long term use:** The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence. **Initial Nursing Assessment and Reassessment** The use of pull-on briefs requires an initial nursing assessment. Reassessment is required whenever there is a prior authorization request for a change in quantity or a medical condition resulting in continued need beyond established policy timelines. Recent discharge from a nursing home or hospital is considered a qualifying condition for short-term use of pull-on briefs. Beneficiaries with medical conditions which result in permanent incontinence or who have product needs over established policy quantities must be re-assessed every 12 months or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file. Pull-on briefs are **not** covered for the following: ▪ Beneficiaries under 3 years of age. ▪ A medical condition causing incontinence of bowel/bladder is not present. ▪ For children who have an occasional bowel or bladder accident. ▪ Night time incontinence of bowel or bladder.
	Incontinent wipes are covered when necessary to maintain cleanliness outside of the home.
	Disposable underpads are covered for beneficiaries of all ages with a medical condition resulting in incontinence.
Standards of Coverage (Applicable to All Programs)	**Intermittent catheters** are covered when catheterization is required due to severe bladder dysfunction. **Hydrophilic-coated intermittent catheters** are considered for individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras. **Intermittent catheters with insertion supplies** are covered for beneficiaries who have a chronic urinary dysfunction for which sterile technique is clinically required.
Documentation	Documentation must be less than 30 days old, kept in the beneficiary file, and include the following: ▪ Diagnosis of condition causing incontinence (primary and secondary diagnosis). ▪ Item to be dispensed. ▪ Duration of need. ▪ Quantity of item and anticipated frequency the item requires replacement. In addition to the above documentation requirements, pull-on briefs require the following: ▪ An initial nursing assessment for all ages, regardless of whether the pull-on briefs will be used short or long term. ▪ A six-month reassessment is required for under 21 years of age or a time determined by MDHHS.

	▪ If the beneficiary has a medical condition that results in permanent incontinence, reassessment is required annually or a time determined by MDHHS. ▪ For under age 21 and attending school, a copy of the teacher's continence report or a letter from the school detailing the bowel/bladder plan. The reassessment must have a copy of the teacher's plan or school letter detailing any changes to the plan and progress made since the last assessment.
PA Requirements	PA is required for: ▪ Hydrophilic type urinary catheters. ▪ usage over the established quantities.
	PA is not required for all other incontinent items unless usage exceeds established quantity limitations.
Payment Rules	**Volume Purchase Agreement** - Through a competitive bid process, the State of Michigan has contracted with a volume purchase contractor for selected incontinent supplies for beneficiaries enrolled in Medicaid FFS and CSHCS. **Beneficiaries Exempt from the MDHHS Volume Purchase Contract -** Based on dual eligibility, specific beneficiaries may be exempt from obtaining services from the MDHHS Volume Purchase Contractor as described below: ▪ Beneficiaries dually enrolled in Medicaid and Medicare are not required to obtain Medicare-covered incontinence items from the contractor but may choose to if preferred. ▪ Beneficiaries enrolled in a MHP will receive coverage of these products through the medical supplier contracted by the health plan. This medical supplier could be the Contractor if negotiated by the MHP. ▪ Beneficiaries enrolled in either a commercial FFS plan or HMO if its coverage includes incontinence supplies are expected to follow the primary payer's rules first. If these products are not covered by the plan, the beneficiary must obtain these items through the MDHHS Volume Purchase Contractor.
Services Covered Through the Contract	The following list details the selected incontinent supply items that must be obtained from the MDHHS Volume Purchase Contractor for Medicaid and CSHCS Programs. Beneficiaries dually eligible for Medicaid and Medicare are required to obtain the contracted incontinent items (designated with an X) from the MDHHS Volume Purchase Contractor.

HCPCS Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/ Medicare
A4310	Insert Tray w/o Bag/Cath	X	
A4311	Catheter w/o Bag 2-Way Latex	X	
A4312	Cath w/o Bag 2-Way Silicone	X	
A4314	Cath w/Drainage 2-Way Latex	X	
A4315	Cath w/Drainage 2-Way Silicone	X	

HCPCS Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/ Medicare
A4320	Irrigation Tray	X	
A4322	Irrigation Syringe	X	
A4326	Male External Catheter	X	
A4328	Female Urinary Collection Pouch	X	
A4330	Perianal Fecal Collection Pouch	X	
A4331	Extension Drainage Tubing	X	
A4333	Urinary Cath Anchor Device	X	
A4334	Urinary Cath Leg Strap	X	
*A4335	Incontinence Supply	X	
A4338	Indwelling Catheter Latex	X	
A4340	Indwelling Catheter, Specialty Type	X	
A4344	Cath Indw Foley 2-Way Silicone	X	
A4349	Disposable Male External Cat	X	
A4351	Straight Tip Urine Catheter	X	
A4352	Coude Tip Urinary Catheter	X	
A4353	Intermittent Catheter w/insertion supplies	X	
A4354	Insertion Tray w/Drainage Bag w/o Cath	X	
A4357	Bedside Drainage Bag	X	
A4358	Urinary Leg Bag or Abdomen Bag	X	
**A4520	Incontinence Garment Any Type		X
A5112	Urinary Leg Bag; Latex	X	
T4521	Adult Size Brief/Diaper SM		X
T4522	Adult Size Brief/Diaper MED		X
T4523	Adult Size Brief/Diaper LG		X
T4524	Adult Size Brief/Diaper XL		X
T4525	Adult Size Pull-On SM		X

HCPCS Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/ Medicare
T4526	Adult Size Pull-On MED		X
T4527	Adult Sized Pull-On LG		X
T4528	Adult Size Pull-On XL		X
T4529	Ped Size Brief/Diaper SM/MED		X
T4530	Ped Size Brief/Diaper LG		X
T4531	Ped Size Pull-On SM/MED		X
T4532	Ped Size Pull-On LG		X
T4533	Youth Size Brief/Diaper		X
T4534	Youth Size Pull-On		X
T4535	Disposable Liner/Shield/Pad		X
T4536	Reusable Pull-On Any Size		X
T4541	Large Disposable Underpad		X
T4542	Small Disposable Underpad		X
T4543	Bariatric Disposable Incontinent Brief/Diaper		X
T4544	Adult disposable incontinence product, protective underwear/pull-on, above extra large		X
S5199	Personal Care Item, NOS (Incontinent Wipe)		X

* Use HCPCS code A4335 only to report belted/unbelted undergarments w/o sides. PA is not required up to the established quantity limit of 150 per month.
** Use HCPCS code A4520 only for moisture resistant reusable incontinence pants.

Quantity Limitations Based on Combination of Items Used	**Diapers and Pull-on Briefs -** For a beneficiary using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. (The maximum amount of pull-on briefs is 150 per month even if the beneficiary is not using diapers.) **Diapers of Different Sizes -** For a beneficiary using a combination of different sized diapers, the total quantity must not exceed 300 per month.

2.20 Lifts (Hydraulic and Electric) [Re-numbered 4/1/2025]

Definition	Lifts include, but are not limited to, hydraulic and electric, and accessories include slings and/or seats.
Standards of Coverage	A standard **hydraulic lift** may be covered when the beneficiary requires assistance in transfers, provision of the lift will allow the beneficiary to be transferred safely, and one of the two conditions stated below are met: ▪ The beneficiary requires a one-person assist but the weight or size of the beneficiary prohibits safe transfers or could cause harm to the caregiver. ▪ The beneficiary requires a two-person assist and there are not two caregivers in the home. An **electric lift** may be covered when the above Standards of Coverage are met and the hydraulic lift cannot be used safely or when the beneficiary's medical condition results in increased tone (e.g., spasticity).
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the lift. ▪ Functional level of assistance required to complete activities of daily living (ADLs). ▪ Type of transfer required. ▪ Weight and height of the beneficiary. ▪ Type of lift requested. ▪ An occupational or physical therapy evaluation and recommendation. ▪ Number of caregivers in the home and number of hours during the 24-hour period that each caregiver is present.
PA Requirements	PA is not required if Standards of Coverage are met for**:** ▪ Hydraulic lifts ▪ Replacement slings or seats
	PA is required for: ▪ Electric lifts ▪ Replacement within ten years
Payment Rules	A lift may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.21 Mechanical In-Exsufflation Device [Re-numbered 4/1/2025]

Definition	A mechanical in-exsufflation device is a portable electric device that utilizes a blower and a valve to alternately apply a positive and then a rapid negative pressure to an individual's airway to assist the person to cough more effectively.
Standards of Coverage	A mechanical in-exsufflation device may be covered for up to four months if the following applies: ▪ Diagnosis of respiratory failure due to neuromuscular deficits. ▪ Beneficiary is unable to cough or clear secretions effectively due to reduced peak expiratory force. ▪ Other treatment modalities have not been effective (e.g., inhalers, PEP mask therapy, or flutter devices). For coverage beyond four months, continued use of a mechanical in-exsufflation device may be covered when there is continued effectiveness.
Documentation	Documentation must be less than 180 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current treatment modalities and any others already tried. ▪ Documentation of beneficiary's ability to use. ▪ Plan of care from a pulmonologist substantiating need for this device is **required under the CSHCS program.** ▪ For coverage beyond the first four months, medical statement substantiating continued effectiveness.
PA Requirements	PA is required for all requests.
Payment Rules	A mechanical in-exsufflation device is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, filters etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.22 Nebulizer [Re-numbered 4/1/2025]

Definition	A nebulizer is a powered device that allows a medication to be changed from a liquid to a mist so it may be effectively inhaled into the lungs. Types of nebulizers include, but are not limited to, standard and ultrasonic.

Standards of Coverage	A **standard nebulizer** device may be covered if: ▪ The beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, bronchopulmonary dysplasia, chronic obstructive pulmonary disease [COPD], etc.). ▪ The physician has already considered use of a metered dose inhaler and it was insufficient to meet the needs of the beneficiary. An **ultrasonic nebulizer** is covered when a standard nebulizer is ineffective.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition requiring use of the nebulizer. ▪ Medications prescribed. ▪ Frequency of administration. ▪ Medical reason economic alternatives are ineffective. ▪ For an ultrasonic nebulizer, pulmonary function testing done after use of a standard nebulizer and after use of an ultrasonic nebulizer showing the ultrasonic is more efficacious.
PA Requirements	PA is not required if Standards of Coverage are met for standard nebulizer and associated accessories up to established quantity limits.
	PA is required for: ▪ Ultrasonic nebulizer. ▪ Replacement of standard nebulizer within five years. ▪ When the Standards of Coverage are not met.
Payment Rules	A nebulizer is considered either a **capped rental** or **purchase** item. Accessories are separately reimbursable. If the unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.23 Negative Pressure Wound Therapy (Pump and Accessories) [Re-numbered 4/1/2025]

Definition	Negative pressure wound therapy (NPWT) utilizes a sub-atmospheric (negative) pressure technique to reduce edema, increase localized blood flow and granulation tissue formation, and remove exudates from the wound. The NPWT pump must be able to apply pressure intermittently or continuously in a range from 25 - 125 mm HG and accommodate multiple wounds.

Standards of Coverage	Negative pressure wound therapy is covered for short-term therapy (7 to 14 days) if one of the following conditions applies and failure of several less expensive treatment modalities has occurred: ▪ Stage III or IV pressure ulcer(s) - ➢ Beneficiary has been part of a comprehensive ulcer management program (e.g., appropriately turned and positioned, appropriately managed for either moisture or incontinence, received adequate nutritional support, etc.) for at least the last 30 days. ➢ Beneficiary has used either a Group 2 or 3 Support Surface for at least the last 30 days. ▪ Diabetic Ulcers - Beneficiary has been on a comprehensive diabetic management program. ▪ Venous stasis ulcers - ➢ Compression bandages have been applied consistently. ➢ Mobility and leg elevation have been encouraged. ▪ Dehisced incisions or traumatic wounds - Wound care clinical protocols have been ineffective.
Documentation	All documentation, except wound measurements, must be less than 30 days old. Documentation of wound measurements must be less than seven days old and include the following: ▪ Evaluation, care and wound measurements by a licensed medical professional. ▪ All previous dressings tried. ▪ Debridement of necrotic tissue, if applicable. ▪ Evaluation and provision of adequate nutritional status. ▪ Appropriate turning/repositioning schedule. ▪ Incontinence management, if applicable. ▪ Appropriate pressure reduction addressed if wound is pressure related.
Continued Coverage	For continued coverage beyond the initial 7 to 14 days, documentation must be submitted detailing updated wound measurements and substantiate continued effectiveness.
PA Requirements	PA is required for all requests. HCPCS codes A6550, A7000 and E2402 require authorization via a telephone prior authorization process. (Refer to the Directory Appendix for MDHHS Program Review Division telephone prior authorization of specified DME and medical supplies information.)
Payment Rules	A negative pressure wound therapy pump is a **rental only** service. Payment for the pump is considered as a daily rental rate by reporting total number of days used as units. The canister and dressing set are considered **purchase** items and may be separately reimbursed from the pump code.

2.24 Orthopedic Footwear [Re-numbered 4/1/2025]

Definition	Orthopedic footwear may include, but are not limited to, orthopedic shoes, surgical boots, removable inserts, Thomas heels, and lifts.
Standards of Coverage	**Orthopedic shoes and inserts** may be covered if any of the following applies: ▪ Required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater. ▪ Required to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fascitis. ▪ Required to accommodate a brace (extra depth only are covered). **Surgical Boots or Shoes** may be covered to facilitate healing following foot surgery, trauma or a fracture.
Noncovered Items	Shoes and inserts are noncovered for the conditions of: ▪ Pes Planus or Talipes Planus (flat foot) ▪ Adductus metatarsus ▪ Calcaneus Valgus ▪ Hallux Valgus Standard shoes are also noncovered.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification. ▪ Functional need of the beneficiary. ▪ Reason for replacement, such as growth or medical change. **CSHCS requires** a prescription from an appropriate pediatric subspecialist.

PA Requirements	PA is not required for the following items if the Standards of Coverage are met: ▪ Surgical boots or shoes. ▪ Shoe modifications, such as lifts, heel wedges, or metatarsal bar wedges up to established quantity limits. ▪ Orthopedic shoe to accommodate a brace. ▪ Orthopedic shoes and inserts when the following medical conditions are present: ➢ Plantar Fascial Fibromatosis ➢ Unequal Leg Length (Acquired) ➢ Talipes Equinovarus (Clubfoot) ➢ Longitudinal Deficiency of Lower Limb, Not Elsewhere Classified ➢ Unilateral, without Mention of Complication (Partial Foot Amputation) ➢ Unilateral, Complicated (Partial Foot Amputation) ➢ Bilateral, without Mention of Complication (Partial Foot Amputation) ➢ Bilateral, Complicated (Partial Foot Amputation)
	PA is required for: ▪ All other medical conditions related to the need for orthopedic shoes and inserts not listed above. ▪ All orthopedic shoes and inserts if established quantity limits are exceeded. ▪ Medical need beyond the Standards of Care. ▪ Beneficiaries under the age of 21, replacement within six months. ▪ Beneficiaries over the age of 21, replacement within one year.
Payment Rules	These are **purchase only** items.

2.25 ORTHOTICS (CERVICAL) [RE-NUMBERED 4/1/2025]

Definition	Cervical orthotics include, but are not limited to, cervical collars and cranial helmets.
Standards of Coverage	**Cervical collars** may be covered to facilitate healing and/or restrict mobility for the following indications: ▪ Pre- and post-surgery ▪ Pre- and post-cervical fusion ▪ Cervical trauma ▪ Post fractures

	Cervical helmets may be covered to prevent head injury for beneficiaries with medical conditions affecting balance that predisposes them to fall. For the medical condition of plagiocephaly, a **custom fabricated cranial remolding orthosis** is covered and must include the following: ▪ Proper measurements including topography, casting, etc. ▪ The use of a FDA registered helmet. ▪ All necessary follow-up visits, including fitting and adjustments, for 18 months after placement.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For repairs, a copy of the physician's prescription at the time of original placement and itemization of materials used to repair appliance or rationale for related labor costs must be documented.
PA Requirements	PA is not required when the Standards of Coverage are met for: ▪ Cervical collars. ▪ Nonmolded cranial helmets. ▪ Molded cranial helmets for a beneficiary under the age of one year with diagnosis of plagiocephaly when prescribed by an appropriate pediatric subspecialist. ▪ Repairs as follows: ➢ The total repair cost equals one hour of labor or less ➢ The cost of minor parts equals $50 or less
	PA is required for: ▪ Custom molded cranial helmets for conditions other than plagiocephaly. ▪ Replacement of a cranial nonmolded helmet or cervical collar within one year. ▪ Repair costs exceed the maximum limits as stated above.
Payment Rules	These are covered as **purchase only** items.

2.26 Orthotics (Lower Extremity) [Re-numbered 4/1/2025]

Definition	Lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.
Standards of Coverage	Lower extremity orthotics (including night splints), regardless of diagnosis, are covered for the following manifestations: ▪ To promote healing and/or proper alignment/positioning following injury, procedure (e.g. serial casting), or surgery of the lower extremity. ▪ To support lower extremities due to muscle weakness or abnormal muscle tone (e.g. high/low fluctuating tone) of permanent or long-standing duration (six months or longer). ▪ To support, correct or improve: ➢ Biomechanical alignment (e.g. pronation, supination, varus or valgus). ➢ Static or dynamic contractures. ➢ Congenital or acquired deformities of the lower extremities.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested including current functional level. ▪ A physical therapy evaluation may be required on a case-by-case basis when PA is required. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** ▪ Medical justification for each additional component required. For repairs, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Fracture orthosis for fractures. ▪ Hip orthosis for Legg Perthes. ▪ Prefabricated knee appliances. ▪ Custom-fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament. ▪ Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO). ▪ Custom-fabricated plastic AFOs if up to four additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface).

	▪ Custom-fabricated metal AFOs if up to six additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition to the other items. ▪ Custom-fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions). ▪ Custom-fabricated metal KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition the other items. If other add-on items not listed above or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less. PA is required for: ▪ Custom fabricated knee orthoses for all other diagnoses/medical conditions. ▪ Hip Knee Ankle Foot Orthosis (HKAFO) for all other diagnoses/medical conditions. ▪ Fracture orthosis for all other diagnoses/medical conditions. ▪ Other base codes or additional codes indicated as requiring PA in the Medicaid Code and Rate Reference tool. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within six months for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.27 ORTHOTICS (SPINAL) [RE-NUMBERED 4/1/2025]

Definition	Spinal orthotics include, but are not limited to, cervical, thoracic, lumbar, sacral, spinal, thoracic mid belt lumbar sacral, and sacroiliac orthotics.
Standards of Coverage	Spinal orthotics are covered to: ▪ Facilitate healing following a spinal injury. ▪ Arrest or correct the curvature of the spine or spondylolisthesis greater than grade 1. ▪ Support weak spinal muscles due to atrophy and/or a deformed spine. ▪ Facilitate healing following spinal surgery.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For **repairs**, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic, itemization of materials used to repair the appliance, and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated thoracic-lumbar-sacral orthosis (TLSO) ▪ Prefabricated lumbar sacral orthosis (LSO) ▪ Prefabricated sacroiliac supports ▪ Cervical-Thoracic-Lumbar -Sacral Orthosis (CTLSO) for the treatment of curvature of the spine

	▪ Custom-fabricated TLSOs, LSOs, and sacroiliac supports for the base code and up to three additional components indicated in the Medicaid Code and Rate Reference tool and with one of the following diagnoses: ➢ Neurofibromatosis, Type 1 ➢ Scoliosis (and Kyphoscoliosis), Idiopathic ➢ Progressive Infantile Idiopathic Scoliosis ➢ Curvature of Spine (Scoliosis) ** ➢ Certain Congenital Musculoskeletal Deformities of the Spine ➢ Spondylolisthesis **Curvature of the spine (scoliosis) must be listed in conjunction with the other conditions of Charcot-Marie-Tooth Disease or Neurofibromatosis to not require PA. ▪ For **repairs**, up to two episodes per year, as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Diagnoses/medical conditions not removed from PA. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within one year, for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years, for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.28 ORTHOTICS (UPPER EXTREMITY) [RE-NUMBERED 4/1/2025]

Definition	Upper extremity orthotics include, but are not limited to, shoulder, elbow, wrist, and hand orthotics.
Standards of Coverage	Upper extremity orthoses are covered: ▪ Following an acute cerebral vascular accident. ▪ To support weak muscles due to a neuromuscular condition. ▪ Facilitate healing immediately following surgery. ▪ Improve function due to a congenital paralytic syndrome (e.g., Muscular Dystrophy).

Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is **required under the CSHCS program.** For **repairs**, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.
PA Requirements	PA is not required for the following if the Standards of Coverage are met: ▪ Prefabricated shoulder orthosis (SO), elbow orthosis (EO) and shoulder-elbow-wrist-hand orthosis (SEWHO). ▪ Custom fabricated SOs, EOs and SEWHOs if the base code and up to two additional components are needed. ▪ Prefabricated upper extremity fracture orthosis if the treatment is related to a fracture related condition. ▪ Custom fabricated upper extremity fracture orthosis if the base code and up to two additional components are needed. ▪ Prefabricated wrist-hand-finger orthosis (WHFO) and hand-finger orthosis (HFO). ▪ For **repairs** as follows: ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals $50 or less.
	PA is required for: ▪ Custom fabricated WHFOs and HFOs. ▪ Repair costs that exceed the maximum limits as stated above. ▪ Replacement within one year, for a beneficiary under the age of 21, from the original service date. Replacement within two years, for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as **purchase only** items.

2.29 OSTEOGENESIS STIMULATORS [RE-NUMBERED 4/1/2025]

Definition	An Osteogenesis Stimulator is a device that provides electrical or ultrasonic signal stimulation to augment bone repair. Osteogenesis stimulators include: ▪ Noninvasive electrical stimulator characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site; or

	▪ Noninvasive electrical multi-level spinal stimulator which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); or ▪ Noninvasive low intensity ultrasound stimulator which produces pulsed ultrasonic signals rather than electricity to stimulate bone repair by applying the signal to the skin surface at the fracture site. A long bone is limited to the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal. The FDA classifies osteogenesis stimulators as Class III devices.
Standards of Coverage	A **noninvasive, nonspinal electrical or low intensity ultrasonic osteogenesis stimulator** may be covered when other treatment methods have been ineffective and when one of the following applies: ▪ There is a nonunion of a long bone fracture with radiographic evidence which indicates that the fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator. ▪ There is a nonunion of a nondisplaced scaphoid fracture. ▪ If there is failed fusion of a joint, other than in the spine, where a minimum of nine months has elapsed since the surgery. ▪ Congenital Pseudoarthrosis not due to lack of skeletal maturity. ▪ The fracture gap is < = 1 cm. ▪ A nonunion of a long bone fracture as described by the appropriate ICD code. Treatment using the above stimulators may not be provided concurrently.
	A **spinal electrical osteogenesis stimulator** may be covered when other treatment methods have been ineffective and when one of the following applies: ▪ There is a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. ▪ Following multi-level (three or more vertebrae) spinal fusion surgery without instrumentation. ▪ Clinical indication in cervical spine fusions with instrumentation (reviewed on case by case basis). ▪ Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same level(s). How long ago was the failure? ▪ May also be indicated as an adjunct to high-risk fusion; cases that meet one or more of the following criteria: ➢ Smoking (cessation attempts) ➢ Diabetes ➢ Metabolic disease where bone healing is likely to be compromised ➢ Grade III or greater spondylolisthesis Treatment using the above stimulator may not be provided concurrently with nonspinal osteogenesis stimulators.

<table>
<tr><td>Covered Conditions</td><td>The current International Classification of Diseases (ICD) code related to the type and location of the fracture must be reported by the physician on the prescription/order and in the medical documentation.
<table><tr><td>Long Bone Fractures</td><td>• Clavicle
• Humerus
• Radius* and ulna
• Femur
• Fracture of other and unspecified parts of femur
• Tibia* and fibula
• Metacarpal bones (hands)
• One or more tarsal and metatarsal* bones</td></tr><tr><td>Other Fractures</td><td>• Ankle
• Closed navicular (scaphoid*) of wrist
• Malunion of fracture
• Nonunion of fracture
• Acquired spondylolisthesis
• Congenital spondylolisthesis</td></tr></table>*Coverage of fresh fractures is limited to tibia, radius, scaphoid, and fifth metatarsal.</td></tr>
<tr><td>Non-Covered Conditions</td><td>Medicaid does not cover the use of a bone growth stimulator for any of the following indications as it is considered experimental, investigational, or unproven (not all inclusive):
▪ Fresh fractures (other than when using ultrasound bone stimulation for the tibia or radius)
▪ Toe fractures
▪ Sesamoid fractures
▪ Avulsion fractures
▪ Osteochondral lesions
▪ Stress fractures
▪ Displaced fractures with malalignment
▪ Synovial pseudoarthrosis
▪ Fractures related to malignancy
▪ The bone gap is either > 1 cm or > one-half the diameter of the bone
▪ Primary surgeries with current internal fixation techniques (i.e., pedical screw fixation and variants)
▪ Lack of skeletal maturity (refer to congenital pseudoarthrosis)</td></tr>
<tr><td>Documentation</td><td>Documentation must be less than 90 days old and include all of the following:
▪ Diagnosis/medical condition related to the need for the device.
▪ Alternative treatment methods tried and results.</td></tr>
</table>

	▪ For a diagnosis of fracture nonunion, reports of sequential x-ray results for a period of no less than 90 days and office records, including previous treatments and operative procedures (if any). ▪ For a spinal fusion procedure, pertinent office and/or hospital records as well as a legible, complete description of indications for electrical stimulation. A copy of the operative report(s) may be required. ▪ Other modalities still to be used (include type and location).
PA Requirements	PA is required and approved for three months at a time for up to a maximum of ten months. For consideration of rental beyond the initial three months, a new MSA-1653-B must be submitted, along with physician documentation establishing medical reason(s) for continued need.
Payment Rules	Osteogenesis stimulators are considered a capped rental item and are inclusive of the following: ▪ All accessories needed to use the unit (e.g., electrodes, wires, cables, coupling gel, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional based on manufacturer warranty. <u>After purchase:</u> Accessories needed to use the device, or the replacement of the stimulator, require prior authorization. The manufacturer's warranty must be exhausted prior to requesting a replacement osteogenesis stimulator.

2.30 OSTOMY SUPPLIES [RE-NUMBERED 4/1/2025]

Definition	Ostomy supplies are those products necessary to maintain and care for a temporary or permanent stoma and include, but are not limited to, belts, barriers, adhesive remover, filters and pouches.
Standards of Coverage	**Standard wear ostomy products** are changed daily and are covered for specified quantities when the beneficiary has an ostomy. **Extended wear ostomy products** may be covered when change is not required on a daily basis. The quantities must match manufacturers' recommendations for use.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Appliance required. ▪ Quantity of item. ▪ Frequency of change. ▪ Type and location of ostomy. ▪ Condition of the skin surface surrounding the stoma.

PA Requirements	PA is not required for ostomy supplies up to established quantity limits.
	PA is required for quantities above established program limits.
Payment Rules	These are **purchase only** items.

2.31 Oxygen, Oxygen Equipment and Accessories [Re-numbered 4/1/2025]

Definition	Oxygen therapy includes, but is not limited to, stationary compressed systems, portable gaseous systems, stationary liquid systems, portable liquid systems, and concentrators.
Standards of Coverage	Stationary oxygen equipment and accessories may be covered in the home setting for either short-term (less than six months) or long-term (six months or greater) use. **For beneficiaries under age 21**, oxygen therapy may be covered when oxygen is required during a variety of activities (e.g., sleeping, feeding, resting) and there is an oxygen saturation rate of 93 percent or below or PO2 level of 65 mm HG or below.
	For beneficiaries age 21 and older, when the beneficiary requires oxygen for continuous use (test taken while the beneficiary is at rest, breathing room air), nocturnal use (test taken while sleeping), or exercise use (test taken during exercise) and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below. Once the Standards of Coverage are met, the type of equipment covered is determined by the following: ▪ Medical diagnosis and/or condition related to the need for oxygen. ▪ Activity level. ▪ Amount of liter flow needed. The three main types of oxygen systems are: ▪ **Compressed Oxygen System** – Used primarily for intermittent use or low liter flow requirements (less than one liter per minute). A portable unit may be authorized if activities cannot be accomplished by the use of a stationary unit alone. ▪ **Concentrators -** Used for higher liter flows, usually one liter or more. A portable compressed oxygen unit may be authorized if activities cannot be accomplished by the use of a concentrator alone. ▪ **Liquid Oxygen System -** Used for high liter flow requirements. Liter flow must be ordered at more than four liters per minute. In cases where liquid oxygen is inappropriate, a compressed gas or concentrator system could be covered if criteria for that unit are met.

Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition appropriate for the need of oxygen. ▪ Required liter flow (e.g., two liters per minute). An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Hours used per day (e.g., eight hours a day). For intermittent use (less than eight hours per day), indicate activity or time of day. An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Duration of need (e.g., three months, six months or lifetime). ▪ Delivery system to be used (e.g., concentrator, compressed gas, liquid). ▪ Current PO2 or oxygen saturation level while on room air. ▪ For liquid oxygen, total number of pounds required per month. ▪ A prescription from a pediatric pulmonologist, a neonatologist, a pediatrician intensivist, and/or pediatric cardiologist is **required under the CSHCS program.**
	Equipment Maintenance - Verification of the proper use, care and function (e.g., verification that the equipment delivers the proper percentage of liter flow) must be performed according to the manufacturer's requirements. The following information must also be maintained in the patient's file: ▪ The name of the manufacturer. ▪ The manufacturer's requirements for verification of proper use, care and function of the equipment. ▪ The date that each equipment verification was performed. **Six-Month Recertification** - After the initial prescription for home oxygen therapy, a six-month follow-up certificate of medical necessity (CMN) must be obtained. At this time, a new pO2 or oxygen saturation test with the beneficiary on room air must be obtained and indicated on the CMN, along with the date of the test, to substantiate continued need for treatment. **Annual Recertification** - Following the first year of oxygen treatment, a new CMN and prescription are required annually. An updated lab test is not required unless there is a change in the level of oxygen usage or type of delivery system required. The most recent pO2 or oxygen saturation level and the date of the test must be documented on each annual CMN.

PA Requirements	PA is not required for gaseous stationary, concentrators, and portable oxygen systems if the Standards of Coverage are met and the beneficiary has one of the following diagnoses descriptions: ▪ Bronchiectasis ▪ Bronchopulmonary Disease ▪ Chronic Airway Obstruction ▪ Chronic Bronchitis ▪ Chronic Pulmonary Heart Disease ▪ Coccidioidomycosis ▪ Congenital Central Alveolar Hypoventilation Syndrome ▪ Congenital Heart Disease ▪ Heart Failure ▪ Idiopathic Sleep Related Nonobstructive Alveolar Hypoventilation ▪ Malignant Neoplasm of Trachea, Bronchus, and Lung ▪ Muscular Dystrophies and other Myopathies ▪ Myoneural Disorders ▪ Other Alveolar and Parietoalveolar Pneumonopathy ▪ Other and Unspecified Disorders of Metabolism (Cystic Fibrosis) ▪ Other Diseases of Blood and Blood -Forming Organs (Secondary Polycythemia, Familial Polycythemia) ▪ Other Emphysema ▪ Pneumoconioses and other Lung Diseases due to External Agents ▪ Postinflammatory Pulmonary Fibrosis ▪ Primary Central Sleep Apnea ▪ Pulmonary Eosenophilia ▪ Pulmonary Tuberculosis ▪ Secondary Malignant Neoplasm of Respiratory and Digestive Systems ▪ Sleep Related Hypoventilation Hypoxemia in Conditions Classified Elsewhere ▪ Tracheomalacia ▪ PA is not required for gaseous stationary or concentrators for the condition of obstructive sleep apnea (adult) (pediatric). PA is required for: ▪ Oxygen required for short-term use only ▪ Liquid oxygen systems ▪ Liquid oxygen contents only ▪ Medical need for long-term oxygen use does not meet Standards of Coverage

Payment Rules	All oxygen equipment is a **rental only** and is inclusive of the following: ▪ All necessary accessories (e.g., regulator, tubing, mask or cannula, contents base, etc.). Stationary gaseous or liquid oxygen contents are separately payable only when the patient owns the equipment and the coverage criteria has been met. ▪ The rental payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional. The equipment should be checked according to manufacturer's specifications.
	Combination of Equipment Covered: ▪ Only one delivery method is covered per month (i.e., gaseous, gaseous/concentrator or liquid). ▪ A portable compressed gaseous system or liquid system will only be provided in addition to an existing stationary system, unless oxygen is needed for ambulation only. ▪ A backup cylinder is considered part of the inclusive reimbursement for the oxygen system.
	Nursing Facility Residents: ▪ For a nursing facility resident, the DME provider may bill for oxygen gas, equipment, and supplies only when used for prolonged daily use. Intermittent or infrequent use of these items is included in the nursing facility per-diem rate. Based on this site of service, the monthly rental payment issued to the DME provider for the oxygen concentrator will be reduced compared to the payment for equipment used in the home. ▪ For a County Medical Care Facility or Hospital Long Term Care Unit, the DME provider cannot bill for oxygen gas, equipment and supplies for any resident. NOTE: The rental of a concentrator **is** billable by a Medical Supplier. Frequent or prolonged use is defined as: ▪ Long-term daily basis. ▪ At least eight hours duration or more per day.

2.32 PARENTERAL NUTRITION [RE-NUMBERED 4/1/2025]

Definition	Parenteral nutrition is the provision of nutrition intravenously.
Standards of Coverage	Parenteral nutrition may be covered when: ▪ There is an impairment or disease of the gastrointestinal tract that impairs the ability of nutrients to be digested and absorbed. ▪ Post-surgical nonabsorption from a recent massive small bowel resection leaving less than five feet of small bowel remaining beyond the ligament of Treitz or short bowel syndrome with severity that involves a net gastrointestinal fluid and electrolyte malabsorption in which the enteral losses exceed 50 percent of oral/enteral intake.

Documentation	Documentation must be less than 30 days old and include the following: ▪ Specific diagnosis related to the beneficiary's inability to take or eat regular food. ▪ Amount of nutrients needed per day. ▪ Duration of treatment. ▪ Current height, weight, and recent weight loss. ▪ Identification of levels of individual nutrient(s) that are required in increased or restricted amounts.
PA Requirements	PA is not required for parenteral equipment, supplies, and solutions when the Standards of Coverage have been met and one of the following diagnoses exists: ▪ Noninfectious Enteritis of the Small Intestine ▪ Noninfectious Enteritis of the Large Intestine ▪ Unspecified Intestinal Obstruction ▪ Fistula of Intestine, Excluding Rectum and Anus ▪ Acute Pancreatitis ▪ Chronic Pancreatitis ▪ Cyst and Pseudocys of Pancreas ▪ Other and Unspecified Post-Surgical NonAbsorption When PA is required, the following HCPCS codes are authorized via a telephone authorization process: B4185, B4189, B4193, B4197, B4199 B4220, B4224, B9004, B9006, B9999 Refer to the Directory Appendix for MDHHS Program Review Division telephone prior authorization of specified DME and medical supplies information.
Payment Rules	Parenteral nutrition must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other. If reporting parenteral lipids without one of the parenteral pre-mix solutions, only the pump code is separately reimbursable. The administration kit includes all items necessary for the administration of the solution (e.g., the extension sets, pump cassettes, clamps, containers, and connectors). The supply kit includes all necessary medical supplies such as dressings, tape, alcohol wipes, filters, syringes, needles, and injection caps. For Medicaid beneficiaries residing in a nursing facility, the parenteral solution, equipment and supplies may be billed by the medical supplier.

2.33 Peak Flow Meter [Re-numbered 4/1/2025]

Definition	A peak flow meter is a small device used to measure the airflow out of the lungs.
Standards of Coverage	A peak flow meter may be covered if the beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, COPD).

Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/condition related to the need for the meter. ▪ Frequency of use.
PA Requirements	PA is not required if the Standards of Coverage have been met**.**
	PA is required when: ▪ Medical need is beyond Standards of Coverage. ▪ Replacement is required within one year.
Payment Rules	This is a **purchase only** item.

2.34 Phototherapy (Bilirubin) Light with Photometer [Re-numbered 4/1/2025]

Definition	A phototherapy light with photometer is an ultraviolet light source used to reduce bilirubin levels.
Standards of Coverage	A phototherapy light may be covered if: ▪ The beneficiary is being treated for the diagnosis of neonatal jaundice. ▪ The treatment is limited to seven consecutive days and occurs during the first 30 days of life.
Documentation	Documentation must be less than 24 hours old and include: ▪ Diagnosis/condition related to the need for the device. ▪ Duration of need.
PA Requirements	PA is not required if the Standards of Coverage are met and there is one of the following diagnoses: ▪ Optic Papillitis ▪ Hemolytic Disease due to Other and Unspecified Isoimmunization ▪ Perinatal Jaundice from Other Excessive Hemolysis ▪ Neonatal Jaundice Associated with Pre-term Delivery ▪ Neonatal Jaundice due to Delayed Conjugation from Other Cases ▪ Unspecified Fetal and Neonatal Jaundice ▪ Kernicterus not due to Isoimmunization
	PA is required for: ▪ Diagnosis/medical condition other than those listed above. ▪ Medical need is beyond the Standards of Coverage.

Payment Rules	A phototherapy light with photometer is a **rental only** item, and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., ultraviolet light source, a fiberoptic system with fiberoptic blanket if needed, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.35 Pneumatic/Non-pneumatic Compressors and Appliances (Lymphedema Pump) [Re-numbered 4/1/2025]

Definition	Pneumatic/non-pneumatic compressors (lymphedema pumps) and appliances (sleeve/garment) apply pressure to a limb to remove excess fluid from the limb. The compressor may be pneumatic (uses air to compress) or non-pneumatic (other compression mechanism used such as nickel-titanium shape-memory alloy). The compressor and appliance may be either non-segmented (single chamber) or segmented (multiple chambers) with or without calibrated gradient pressure. An integral part of treatment, along with the pneumatic/non-pneumatic compression device, is leg or arm elevation and the use of custom fabricated gradient pressure stockings or sleeves, compression bandaging, etc.
Standards of Coverage	A pneumatic/non-pneumatic compression device may be covered only as a treatment of last resort (e.g., other less intensive treatment has not been effective). A **nonsegmented device or segmented device without manual control** of the pressure in each chamber may be covered for up to 90 days for any of the following: ▪ Radical surgical procedures with removal of regional groups of lymph nodes (e.g., radical mastectomy) ▪ Post-radiation fibrosis ▪ Metastasis of malignant tumors to regional lymph nodes with lymphatic obstruction ▪ Scarring of lymphatic channels if: ➢ There is significant ulceration of the lower extremity(ies); and ➢ The beneficiary has received repeated, standard treatments from a physician using such methods as a compression bandage system or its equivalent. ▪ Treatment of chronic venous insufficiency with edema and/or venous ulcers ▪ Milroy's Disease ▪ Congenital anomalies ▪ Refractory lymphedema related to venous insufficiency complicated by recurrent cellulitis (scarring of the lymphatic channels) A **segmented device with calibrated gradient pressure** may be covered when there is a painful focal lesion (e.g., significant sensitive skin scar or contracture) of the extremity that requires a reduction in pressure over the affected segment.

Documentation	The documentation must be less than 30 days old and include the following: ▪ Diagnosis/condition appropriate for the equipment requested ▪ Location and size of the painful focal lesion(s) which necessitates the use of the device, if applicable ▪ Length of time each lesion has been continuously present ▪ Plan of treatment, including the frequency and duration of each treatment episode, and anticipated prognosis ▪ Type of unit to be used, the necessary pressure in each chamber, and why the specific features of the equipment are needed ▪ Description of other treatments that have been tried
Continued Use After the Initial 90 Days	For continued coverage beyond the initial 90 days, the following additional information must be provided: ▪ Bilateral limb measurements before and after the approved treatment ▪ Results of the treatment provided
PA Requirements	PA is required for all requests. Coverage will only be provided for one type of compressor (pneumatic or non-pneumatic).
Payment Rules	A unit may be a **capped rental** or **purchase** item. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment ▪ Education on the proper use and care of the equipment ▪ Routine servicing and all necessary repairs or replacements to make the unit functional For purchased items, the manufacturer's warranty must be exhausted prior to requesting a repair or replacement part.

2.36 PRESSURE GRADIENT PRODUCTS [RE-NUMBERED 4/1/2025]

Definition	Pressure gradient products include, but are not limited to, sleeves, wrist gauntlets, vests, legs, etc.
Standards of Coverage	Pressure gradient products may be covered to reduce edema, promote circulation, reduce scarring or reduce retention of fluid in the extremities due to the following conditions: ▪ Lymphedema ▪ Chronic venous insufficiency ▪ Thrombophlebitis ▪ Burns

	Up to two garments may be covered when the items must be worn for 24 hours. Gradient compression stockings are custom-fabricated or custom-measured support and are covered when ordered by a physician to treat one of the above conditions and deliver at least 18 mm HG or greater compression. For custom burn garments, refer to HCPCS codes A6501- A6512. Surgical stockings, such as heavy elastic or anti-embolism stockings, are covered when ordered by a physician as a short-term treatment (up to three months) after a surgical event (e.g., prevent blood clots for non-ambulatory individuals after hospital discharge). If required for treatment during an inpatient hospital stay or outpatient hospital visit, the service will not be reimbursed to the medical supplier.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis of condition being treated ▪ Item to be dispensed ▪ Number of hours to be worn ▪ Location and number of extremities involved
PA Requirements	PA is not required for ready-made pressure gradient products up to established quantity limits.
	PA is required for: ▪ All custom-measured products and special features such as a zipper, enclosed toe, open pubis, etc. ▪ Replacement within three months
Payment Rules	All pressure gradient products are considered a **purchase only** item.

2.37 PROSTHESES [TITLE REVISED 7/1/2025]

2.37.A. LOWER EXTREMITY PROSTHESES [RE-NUMBERED 4/1/2025; TITLE REVISED & RE-NUMBERED 7/1/2025]

Definition	Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemi-pelvectomy prostheses.
Standards of Coverage	A **lower extremity prosthesis** may be covered to restore mobility for a beneficiary who demonstrates the ability to transfer and/or ambulate, and the beneficiary's potential functional level is between the ranges of K1 through K4.
Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current functional "K" level. ▪ An occupational or physical therapy evaluation may be required on a case-by-case basis when PA is required.

PA Requirements	**Below Knee Prosthesis** ▪ Preparatory prosthesis - PA is not required for a BK preparatory prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5510, L5520, or L5530) and the following add-ons: ➢ one test socket ➢ insert ➢ suspension system (e.g., L5666 or L5670) ➢ total contact ➢ distal cushion The SACH foot is included with the BK preparatory base code. If any prosthetic foot other than a SACH foot is placed on a preparatory prosthesis, it will require prior authorization and must be transferred to the definitive prosthesis. ▪ Definitive Exoskeletal BK prosthesis – PA is not required for a BK definitive exoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5100, L5105, L5050) and the following add-ons: ➢ up to two test sockets ➢ socket material ➢ total contact ➢ distal cushion ➢ foot ➢ suspension locking system ➢ insert ➢ liner (e.g., gel, silicone, etc.) ▪ Definitive Endoskeletal BK Prosthesis - PA is not required for a BK definitive endoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5301) and the following add-ons: ➢ up to two test sockets ➢ socket material ➢ total contact ➢ distal cushion ➢ pylon ➢ foot ➢ suspension locking system ➢ insert ➢ liner (e.g., gel, silicone, etc.) ➢ cover Socks and sheaths are not considered as add-ons and would be considered in addition to the other add-on items for either the preparatory or definitive prosthesis.

	Above Knee Prosthesis PA is not required for: ▪ an above knee preparatory prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: one test socket, foot, knee, socket design and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ an exoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, knee, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items. ▪ an endoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other others. Refer to the Medicaid Code and Rate Reference tool for the specific codes removed from PA. For **repairs**, up to two episodes per year, as follows: ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals $50 or less. PA is required for either a below knee or above knee prosthesis when: ▪ The standards of coverage are not met. ▪ Any component part of the prosthesis requires PA. ▪ The beneficiary is over the age of 21 and replacement is required within five years. ▪ The beneficiary is under the age of 21 and replacement is required within two years.
Payment Rules	These are **purchase only** items.

2.37.A.1. MICROPROCESSOR KNEE-SHIN SYSTEMS [RE-NUMBERED 4/1/2025; RE-NUMBERED 7/1/2025]

Standards of Coverage	A microprocessor prosthetic knee-shin system may be covered for a beneficiary with a knee disarticulation amputation, a trans-femoral amputation, a hip disarticulation amputation, or congenital deformity of the lower limb when the following are met: ▪ The beneficiary is motivated to ambulate using a microprocessor knee-shin system; ▪ The beneficiary has the current or potential functional level of K3 or K4;* ▪ The requested system will be the primary mode of ambulation to perform activities of daily living and to access their community; ▪ The beneficiary has the cognitive ability to use the system, understands and can respond to system errors and alerts; ▪ The beneficiary has the physical strength with sufficient pulmonary and cardiovascular reserve to ambulate using the system; ▪ The beneficiary's age and weight meet the manufacturer's system indications; and ▪ The beneficiary has access to a power source to charge the device. A powered and programmable flexion/extension assist control endoskeletal knee-shin system (L5859) is only covered when the beneficiary meets all the following: ▪ Functional level of K3 only; ▪ The beneficiary has a microprocessor swing and stance phase (L5856) knee; ▪ The beneficiary has a comorbidity of the spine or the sound limb that affects the function of hip extension and/or the quadriceps that impairs K3 level function with the use of the microprocessor knee alone; ▪ The beneficiary can charge the system daily; and ▪ The beneficiary can understand and respond to errors and alerts. Note: L5859 is not intended for high impact sports or heavy-duty use. Prior to recommending a microprocessor knee-shin system, providers must consider environmental factors (e.g., high levels of dust, dirt, moisture, etc.) a beneficiary may frequent that may be contraindicated for use of the system. Refer to the above knee definitive prostheses for add-on, sock and sheath information. *Refer to the Billing & Reimbursement for Professionals chapter of this manual for K level definitions.

Documentation	Documentation must be less than 60 days old and include the following: ▪ Diagnosis/medical condition related to the service requested. ▪ Current functional "K" level. ▪ Ordering practitioner documentation substantiating beneficiary physical ability (including ample cardiovascular and pulmonary reserve) to use the device. ▪ Manufacturer warranty for the knee-shin system and componentry (e.g., life of warranty, componentry included in warranty, and include warranty number if the manufacturer issues warranty numbers). ▪ An occupational or physical therapy evaluation may be required on a case-by-case basis when prior authorization (PA) is required.
PA Requirements	PA is required for all microprocessor knee-shin systems. Coverage will only be provided for one type of definitive knee-shin system (e.g., microprocessor, fluid or pneumatic). All conditions of the warranty must be exhausted prior to requesting replacement/repair of the microprocessor knee-shin system and components.
Warranty	The warranty period begins on the date the beneficiary receives the knee-shin system. The warranty information (include life of warranty, items included in the warranty, and warranty number if the manufacturer issues a warranty) must be kept in the beneficiary file and available upon request.
Non-Covered	▪ Microprocessor knee-shin systems for recreational and/or athletic purposes only. ▪ Back-up/secondary prosthetic devices. ▪ Smart devices (e.g., smart phones, iPads, tablets, etc.). These items do not meet the definition of a dedicated medical device. ▪ Prosthetic knees and components covered under the manufacturer warranty. ▪ Upgrades to a microprocessor knee-shin system when the beneficiary's current prosthesis is in good repair, is under Medicaid frequency limits, and continues to meet the beneficiary's medical/functional need.
Payment Rules	Microprocessor knee-shin systems are **purchase only** items.

2.37.B. Upper Extremity Prostheses [Subsection Added 7/1/2025]

Definition	Upper extremity (UE) prostheses are devices used to artificially restore or replace missing, malfunctioning, or congenital limb deficiency/absence of the upper body. Types of UE prostheses include passive, body-powered, myoelectric, and hybrid. The terms prosthetic, prostheses, and prosthesis are used interchangeably, as appropriate, throughout this policy. **Passive** prostheses are not functionally activated, can be lightweight, often require repositioning, can be locked into place (typically by the opposing limb) and are primarily cosmetic but offer postural balance, anatomical symmetry, and can be used for specific activities requiring use of two limbs (e.g., to steady objects). **Body-powered** prostheses use mechanical linkage and/or cable(s), and a body suspension (e.g., body harness) system or method activated by the residual limb, shoulder, or opposite limb to activate the prosthetic device to control extremity movement, positioning and grasping movements. **Myoelectric** (electric) prostheses use surface electrodes (of the residual limb or other strategic body surface) to detect electromyographic signals from the muscle, sending signals to a battery powered controller to control and move the prosthesis. **Hybrid** prostheses utilize a combination of myoelectric and body-powered components to activate the prosthesis for functional movement. This type of prosthetic allows movement of two joints at one time. Hybrids are mainly used for amputations at or above the elbow.
Standards of Coverage	UE prostheses may be covered for beneficiaries of all ages who are physically and cognitively able to utilize a prosthesis at a developmentally age-appropriate level to restore function to a missing or partially missing limb due to amputation or a congenital limb deficiency/absence. **Passive UE Prostheses** A passive UE prosthesis may be covered when the following are met: ▪ The beneficiary has had an amputation or has a congenital limb deficiency or absence of limb. ▪ The beneficiary is physically, developmentally, or cognitively unable or unwilling to use a more advanced (e.g., body- powered) prosthesis and is able and willing to use the passive prosthesis. ▪ The beneficiary can lock the prosthesis in place or, if a child, with the assistance of a parent/caregiver. ▪ For infants (typically between four to six months of age) when developmentally learning to prop sit. ▪ The beneficiary has been evaluated by a clinical team comprised of a physician/non-physician practitioner, prosthetist, occupational therapist (OT) or physical therapist (PT). ▪ The device is the least costly alternative that meets the beneficiary's medical/functional need.

	Body-powered UE Prostheses A body-powered UE prosthesis may be covered when the following are met: ▪ The beneficiary has the cognitive and musculoskeletal ability to perform activities of daily living (ADLs) using the prosthesis. ▪ The beneficiary has had an evaluation by a clinical team and will achieve anticipated functional goals using the prosthesis to accomplish daily living tasks (appropriate to their chronological, developmental, or medical/functional status) in a reasonable time period as identified in the clinical team's (physician/non-physician practitioner, prosthetist, and OT or PT) evaluation and treatment plan. ▪ The beneficiary does not have a comorbidity that may interfere with functional use of the prosthesis. ▪ The device is the least costly alternative that meets the beneficiary's medical/functional need. **Myoelectric or Hybrid UE Prostheses** A myoelectric or hybrid UE prosthesis may be covered when all the above passive and body-powered standards are met, and all the following are met: ▪ A passive or traditional body-powered prosthesis does not meet the beneficiary's functional need to perform ADLs. ▪ The muscle or other body surface to which the electrode is attached can generate sufficient electromyographic signals to operate the prosthesis. ▪ The beneficiary has the endurance to achieve the anticipated functional goals using the prosthesis. ▪ The beneficiary has been evaluated by a clinical team comprised of a physician/non-physician practitioner, prosthetist, OT or PT. ▪ The beneficiary is willing and able to complete training with an OT/PT that specializes in myoelectric UE prostheses and componentry. ▪ Prior to recommending a myoelectric or hybrid prosthesis, the prosthetist must consider environmental factors (e.g., wet environments) a beneficiary may frequent that may be contraindicated for use of the system. **Electric Hand (L6880)** An electric hand may be covered when all the standards for passive, body-powered, myoelectric and hybrid UE prosthesis are met; and all the following requirements are met: ▪ The prosthetist's documentation substantiates the beneficiary requires the electric hand to independently perform ADLs (including, but not limited to, dressing, personal hygiene, toileting, and feeding); and ▪ The beneficiary is willing and able to complete training with an OT/PT that specializes in myoelectric UE prostheses, componentry, and electric hands. Up to two test sockets per limb are permitted prior to the terminal device being delivered. Submitted documentation must establish the medical reason for two test sockets. The prosthesis must be guaranteed to fit for a period of 90 days after delivery of the device (any modifications to the terminal device or componentry within 90 days of delivery are part of the overall service and may not be separately billed).

Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the need for the prosthesis. ▪ The clinical team's (physician/non-physician practitioner, prosthetist, and OT or PT) evaluation and treatment plan. ▪ If the beneficiary has a current prosthesis, documentation of why that prosthesis no longer meets the beneficiary's medical/functional need. ▪ Manufacturer warranty for the prosthesis and componentry (e.g., life of warranty, componentry included in warranty, and include warranty number if the manufacturer issues warranty numbers). ▪ If requesting two test sockets (per limb) for the preparatory prosthesis, documentation must establish the medical reason for two sockets.
PA Requirements	PA is required for all UE prostheses. The manufacturer's warranty must be exhausted prior to requesting repair.
Warranty	The warranty period begins on the date the prosthesis is delivered to the beneficiary. The warranty information (include life of warranty, items included in the warranty, and warranty number if the manufacturer issues a warranty) must be kept in the beneficiary file and available upon request.
Non-Covered	The following are not covered: ▪ Back-up or a second prosthesis. ▪ Devices used solely for recreational purposes. ▪ Upgrades to a myoelectric prosthesis when the beneficiary's current passive or body-powered prosthesis is in good repair, is under Medicaid frequency limits, and continues to meet the beneficiary's medical/functional need. ▪ Replacement of a UE prosthesis and componentry covered under the manufacturer warranty. ▪ Partial hand myoelectric prostheses (e.g., L6026). ▪ More than two liners per year, per prosthesis. ▪ More than two socket inserts per prosthesis.
Payment Rules	UE prostheses are purchase only items. Coverage is provided for accessories or componentry integral to the operation of the device (e.g., hinges, harness, socket). The following are included in the overall prostheses service and not separately reimbursed: evaluation of the member, measurement and/or casting, fabrication, and fitting/adjustments of the prosthesis. There is no separate payment if CAD-CAM technology is used to fabricate the prosthesis as this is included in the code allowance. **(text added per bulletin MMP 25-08)**

2.38 PULSE OXIMETER [RE-NUMBERED 4/1/2025]

Definition	A pulse oximeter is a noninvasive device that measures arterial oxygen saturation levels and pulse rate. The device consists of a sensor attached to the patient's finger or ear lobe that is linked to a processing unit that delivers a read-out.

Standards of Coverage	Pulse oximeter may be covered: ▪ **For beneficiaries 21 or over** as a diagnostic tool for short-term rental (one month) if ordered for oxygen or ventilator weaning in the home. ▪ **For beneficiaries under 21**: ➢ As a diagnostic tool for short-term rental (one month) when there are suspected desaturations during sleep, stress, or feeding. ➢ Up to six months with a diagnosis requiring oxygen use. ➢ Up to six months for beneficiaries with a tracheostomy.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition related to the need for the unit. ▪ Treatment plan addressing what is to be done for abnormal readings. ▪ Current oxygen orders, if applicable. ▪ For coverage beyond the initial six-month period, an evaluation by an appropriate pediatric subspecialist (e.g., pediatric pulmonologist, pediatric cardiologist, neurologist, ENT, or pediatric internist) is **required under the CSHCS program**.
PA Requirements	PA is not required when the Standards of Coverage are met, the beneficiary is under 21, and has one of the following diagnoses: ▪ Tracheostomy (Artificial Opening Status) ▪ Tracheostomy (Attention to Artificial Openings)
	PA is required: ▪ For all beneficiaries over the age of 21. ▪ When the Standards of Coverage are not met.
Payment Rules	A pulse oximeter is a **capped rental** item and is inclusive of the following: ▪ All accessories needed to use the unit (e.g., nondisposable infant or adult oximeter probes, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading of recorded data. If needed for continuous use beyond the 10 months of rental, the item is considered purchased and necessary repairs and/or replacements of accessories are separately reimbursable if not covered under the manufacturer warranty. Replacement of one non-disposable probe annually is separately reimbursable without prior authorization.

2.39 Speech Generating Devices [Re-numbered 4/1/2025]

Definition	Speech generating devices (SGD) are defined as durable medical equipment (electric or nonelectric) that provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet their daily communication needs. Other terms used interchangeably with SGD include augmentative and alternative communication (AAC) device or augmentative communication device (ACD).
Standards of Coverage	To be considered for coverage, documentation must substantiate medical need for beneficiaries whose needs cannot be met using natural communication methods and demonstrate the comprehension and physical skills necessary to communicate using the requested device. An SGD will be considered medically necessary when supporting documentation demonstrates all of the following: ▪ The prognosis for developing and using oral speech as a primary method of communication is considered guarded; ▪ The requested SGD is an integral part of the communication plan of care; and ▪ The beneficiary will be able to use the device in all environments they frequent (e.g., home, school, job, etc.). Software intended for augmentative communication purposes may be considered upon review of documentation supporting medical necessity. If the beneficiary intends to download augmentative communication software onto their personal laptop, computer, or iPad, it is the responsibility of the beneficiary and/or their legal guardian to check with the vendor of the personal device for licensing, compatibility, repair, warranty and proprietary information.
Standards of Coverage – Eye Control	An eye control is a type of mechanism that helps the beneficiary access the SGD. The eye control may or may not be integrated within the speech generating device. Eye control mechanisms will be covered when all of the following apply: ▪ All other methods to operate the SGD have been evaluated and ruled out and the eye control is the most appropriate method that provides a functional level of communication (speed, accuracy, etc.); ▪ Documentation specifies medical, functional and physical necessity that supports the need for the eye control; and ▪ The evaluation(s) has documented evidence of the beneficiary's ability to physically activate the system and demonstrate meaningful use of the device with minimal assistance from others.

Non-covered	The following are non-covered: ▪ Items that do not meet the definition of durable medical equipment and are not dedicated speech devices. ▪ Software to play games, create spreadsheets or documents or is not specific to augmentative communication. ▪ Environmental control units. ▪ More than one SGD per beneficiary. ▪ Registering the device. ▪ Extended warranties. ▪ SGDs used solely for education, vocational or recreational purposes. It is expected that the beneficiary will be able to use the device in all environments they frequent (e.g., home, school, job, etc.). ▪ Replacements based on manufacturer recommended replacement schedules. ▪ SGD requests for devices that do not match the beneficiary's current and reasonably foreseeable communication abilities and needs. ▪ Separate billing for interfaces, cables, adapters or interconnects and switches (with the exception of accessing switches) necessary to interface with the SGD. ▪ Requests for replacement due to new technology when the beneficiary's current SGD continues to meet their medical and functional needs. ▪ Items that are not defined by the American Medical Association, the Food and Drug Administration, and the Pricing, Data Analysis, and Coding (PDAC) contractor as medical devices or dedicated durable medical equipment (e.g., personal tablets, computers, iPads, iPhones, etc.).

Evaluation Components	A speech-language pathologist, in conjunction with other disciplines such as occupational therapists, physical therapists, psychologists, and seating specialists as needed, must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities. Ancillary professionals must possess proper credentials (certification, license and registration, etc.) as appropriate. SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD. An objective evaluation (using objective functional baseline measures and/or standardized testing) of the beneficiary's receptive and expressive communication abilities by a speech-language pathologist (SLP), in conjunction with other applicable disciplines (e.g., occupational therapist, physical therapist, psychologists, and seating specialists, etc.) as needed, has been performed and the SLP has documented the following: ▪ The beneficiary's functional ability to use the device throughout their daily activities. ▪ The consideration of alternative access and positioning devices, as appropriate. ▪ The device is appropriate to the beneficiary's current comprehension, abilities and skills. ▪ The beneficiary demonstrates the cognitive, physical, visual and hearing skills necessary to communicate using the requested device. ▪ The SGD is the least costly device that meets the beneficiary's basic communication needs (in the home and in their community). Include in the evaluation supporting documentation substantiating the requested device as the least costly alternative that meets the beneficiary's current functional needs. ▪ Assessment of the beneficiary on more than one device, by more than one manufacturer, and documenting why the requested device is more appropriate than the other device(s). Include the following in the evaluation: ➢ Device(s) evaluated; ➢ The beneficiary's performance on each device evaluated; ➢ The device requested (brand, make/model and type); and ➢ Reasons why other evaluated devices did not meet the beneficiary's needs. ▪ A trial period using the requested device must be provided for initial device authorization requests. The trial period must be a least one month in length (the SLP may submit a prior authorization request for up to three months). The SLP must document a description of the trial period with the requested device, including length of trial, settings, outcome, and additional training needs identified.

Documentation	Documentation must be within 180 days and include: ▪ the physician's order with the diagnosis directly related to the beneficiary's communication deficit. The order must be based on the SLP's evaluation of the beneficiary's communication abilities and medical needs. ▪ the date of onset, progress made and a comprehensive summary of the beneficiary's communication goals. (Refer to criteria outlined in the Therapy Services Chapter, Speech-Language Therapy subsection.) ▪ the assessment by a physical therapist (PT) or occupational therapist (OT) to address functional mobility and postural control. ▪ the SLP's documentation of hearing and vision status. ▪ a copy, if available, of the hearing (audiologist) or vision (ophthalmologist or optometrist) test if the beneficiary has had a hearing or vision test within the past 12 months. ▪ a plan of care (POC) identifying other disciplines involved in the care and goals for therapy and training. For beneficiaries under the age of 21 attending school, the POC must include other disciplines and parents/legal guardian as appropriate (i.e., OT, PT, psychologist, school therapist, etc.). ▪ specifications for the SGD. (Refer to the Therapy Services Chapter). ▪ necessary therapy and training to allow the beneficiary to meet functional needs. ▪ the speech and language evaluation results. All SGD evaluation documentation must be submitted following the established criteria stated within the Evaluations and Follow-up for Speech Generating Devices/Voice Prostheses subsection of the Therapy Services Chapter. Documentation for modifications/upgrades must describe the changes in the beneficiary's physical, medical, cognitive, vision or hearing status that necessitates the need for the requested modifications/upgrades for the system or parts. A video of the beneficiary using the SGD and/or eye control is a useful tool in establishing the beneficiary's ability to use either item, but is not required. The SLP may submit a video with the prior authorization request if all of the following are met: ▪ The beneficiary or beneficiary's legal guardian has dated and signed an authorization for the video documentation as additional documentation of the beneficiary's ability to use the device; ▪ The video is current (within the past 12 months); and ▪ The provider encrypts the video prior to sending it in with the prior authorization request (following HIPAA compliance regulations).

PA Requirements	The speech-language pathologist performs the functional communication assessment and SGD evaluation and initiates the prior authorization request with a medical supplier that has a specialty enrollment with MDHHS to provide SGDs. To improve beneficiary access to low-end devices, a medical supplier without a SGD specialty enrollment with MDHHS may provide SGDs with eight minutes or less of speech capability, basic SGD accessories such as switches, buttons, etc., or SGD wheelchair mounting systems. A SGD vendor must enroll through the MDHHS CHAMPS PE on-line system as a medical supplier with a subspecialty of Speech Generating Devices in order to provide the full range of SGDs. (Refer to the Directory Appendix for contact information.) PA is required for all SGDs, eye control mechanisms, upgrades, modifications, accessories, repairs, replacements and device trials. Required documentation must accompany the Special Services Prior Approval—Request/Authorization (MSA-1653-B) when requesting authorization for all original and replacement/upgrade SGD requests. A copy of the physician prescription must be submitted with the request for an SGD. The prescription must be based on the evaluation of an individual's communication abilities and medical needs made by a speech-language pathologist and other evaluation team members (as appropriate).
	Modifications/Upgrades - Indicate the procedure code that defines the modification(s) or upgrades. Providers have six months from the prior authorization approval date to provide all approved items, including the SGD, mount and accessories. After six months, a new prior authorization request must be submitted.
	Repairs - For a repair, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed $150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted. Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained. In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDHHS whether to repair or replace the device.
	Replacements - All replacements (identical, upgrades, downgrades) of an SGD require PA.
Follow-Up Services	The provision of speech therapy services for training following the purchase of an SGD is expected to occur within the 12 months following the beneficiary's receipt of the device. (Refer to the Therapy Services Chapter and the Medicaid Code and Rate Reference tool for PA and coverage parameters.) During this time, the SLP and SGD provider are required to ensure that a support team is in place to assist the beneficiary and/or their family with all follow-up SGD needs and therapy.

Frequency	The program will purchase new equipment only. Only one SGD will be purchased within a three-year period for beneficiaries under age 21. Only one SGD will be purchased within five years for beneficiaries age 21 and older. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills.
Warranty	The warranty period begins at the point when the device is in the beneficiary's home and the beneficiary has received adequate training to use the system for functional communication.
Repairs	Repairs for speech generating devices (SGD) are covered after the warranty expires for no more than one SGD per beneficiary. Additionally, repair of an SGD not purchased by MDHHS is covered only if the SGD is determined to be necessary to meet basic functional communication needs in accordance with the criteria for SGD coverage. For a repair, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed $150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted. Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained. In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDHHS whether to repair or replace the device. Technological improvements and upgrades are not considered repairs and must not be requested as such. The prior authorization request for repair must include: ▪ Documentation from the SLP (or if not currently receiving speech services, a physician, a PT or OT, or teacher) confirming the current device is used by the beneficiary on a regular basis and continues to meet the beneficiary's needs; ▪ Part number(s), description(s), manufacturer name, Healthcare Common Procedure Coding System (HCPCS) codes; and ▪ Warranty information and catalog number(s) for the part number(s) to be used for the repair. Repairs must extend the useful lifetime of the SGD by at least one year from the date of the repair request.

Replacements	All replacements (identical, different, upgrades, downgrades) of an SGD require PA. Replacements may be covered when there has been a significant medical/functional change in the beneficiary's ability to use the SGD, the device is no longer repairable, or the cost of repairs exceeds the cost of replacement. Limits for replacement are based on medical/functional need and the operating condition of the beneficiary's current device. Manufacturer suggested replacement schedules are not considered a reason for replacement. When a current SGD needs replacement and the replacement is **identical** to the SGD previously purchased by MDHHS, the documentation required to be submitted with the prior authorization request is: ▪ Clinical confirmation by the speech-language pathologist the device continues to be suitable for the beneficiary's needs; ▪ The SLP, OT or PT confirmation of the beneficiary's functional ability to use the SGD; and ▪ Cost to repair and cost to replace. If an identical SGD is no longer available, a new unit that is equivalent to the original in function, utility and user adaptability will be furnished. When a current SGD needs replacement with an SGD that is **different** than the SGD previously purchased by the program, the documentation to be submitted with the prior authorization is: ▪ A new speech and language evaluation; and ▪ A statement (to be included with the evaluation) indicating why and how the current SGD no longer meets the beneficiary's functional communication needs. All other standards of coverage requirements must be met for coverage consideration. Replacement requests due to loss, damage or theft must include the policy or fire marshal report, as applicable, and a plan to prevent recurrence. MDHHS does not cover replacement of SGDs due to misuse or abuse.
Payment Rules	**Purchase** - MDHHS will purchase new equipment only. The serial number of the device purchased must be maintained on file by the vendor for audit purposes. Shipping and handling fees relating to the SGD equipment are not separately reimbursed. Reimbursement includes the charges for the SGD and all approved components. The provider's charge for an SGD must be based on the usual and customary charge. Reimbursement will be the lesser of the provider's charge and/or the Medicaid fee screen.

	Rental – Equipment will not be rented for a period of less than 30 days and may be rented for a maximum period of 90 days. The monthly rental reimbursement rate will be 1/10 of the maximum purchase reimbursement. The amount reimbursed for rental will be deducted from the total purchase price. MDHHS will apply the trial period rental to the purchase of the SGD. For an SGD device(s) approved for a trial period and ruled out (by the SLP, the beneficiary and/or legal guardian, DME provider, etc.) at some point during the trial period (first, second or third month), MDHHS will reimburse the SGD provider for the period of time the device was trialed. (Refer to the Medical Supplier Database and the Medicaid Code and Rate Reference tool for specific HCPCS codes and rental rates.)

2.40 SUPPORT SURFACES – GROUP 1 [RE-NUMBERED 4/1/2025]

Definition	Pressure Reducing Support Surfaces – Group 1 includes, but is not limited to, alternating pressure pad and pump; water, air, or dry pressure mattresses; or gel or gel-like pressure pads. A Group 1 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 1 mattress overlay or mattress may be covered if one of the following applies. The beneficiary: ▪ Is completely immobile (i.e., cannot make changes in body position without assistance). ▪ Has limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure) with the presence of at least one of these additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status. ▪ Has any stage pressure ulcer on the trunk or pelvis with the presence of at least one of these additional conditions: ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Diagnosis/medical condition related to need for the item. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning.

	▪ Appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Wound size, stage and location (for a Stage II, III or IV ulcer). ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is not required for HCPCS codes A4640, E0184, E0185, E0186, E0187 or E0197 if the Standards of Coverage are met and one of the following diagnoses is present: ▪ Alteration of Consciousness, Coma or Transient Alteration of Awareness ▪ Anoxic Brain Damage ▪ Anterior Horn Cell Disease ▪ Cerebral Degenerations Usually Manifested in Childhood ▪ Cerebral Edema ▪ Compression of Brain ▪ Congenital or Hereditary Progressive Muscular Dystrophy, Myotonic Disorders, Familial Periodic Paralysis ▪ Decubitus Ulcer ▪ Encephalophy, Unspecified ▪ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ Hemiplegia and Hemiparesis ▪ Huntington's Chorea ▪ Infantile Cerebral Palsy ▪ Multiple Sclerosis ▪ Neurofibromatosis ▪ Other Congenital Anomalies of Nervous System ▪ Other Demyelinating Disease of Central Nervous System ▪ Other Paralytic Syndromes ▪ Parkinson's Disease ▪ Spina Bifida ▪ Spinocerebellar Disease PA is required for: ▪ Medical need beyond the Standards of Coverage. ▪ All other diagnoses. ▪ Replacement in less than three years.

Payment Rules	A Group 1 support surface may be a **capped rental** or **purchase** depending on the specific HCPCS code. Only a single Group 1 support surface will be considered for a purchase/rental at any given time. If unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment (e.g., pump, pad, cards etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.

2.41 SUPPORT SURFACES – GROUP 2 [RE-NUMBERED 4/1/2025]

Definition	Pressure Reducing Support Surfaces - Group 2 includes, but is not limited to, powered air flotation beds; powered pressure-reducing air mattresses; powered air overlay for mattress; or nonpowered advance pressure reducing mattress. A Group 2 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.
Standards of Coverage	A Group 2 mattress support may be covered up to three months when one of the following applies: ▪ Multiple Stage II pressure ulcers are located on the trunk or pelvis and the beneficiary has participated with a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface, and the wound has worsened or had no change. ▪ Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis. ▪ Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and the beneficiary has been on a Group 2 or 3 surface immediately after a recent discharge from a hospital or nursing facility (discharge within the past 30 days).
	Continued Use of a Group 2 support surface **-** Continued use of a Group 2 support surface on a monthly basis may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 2 support surface on a monthly basis will not be reauthorized for coverage if: ▪ The beneficiary is noncompliant with care plan; or ▪ The documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to need for item. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities/surfaces already tried.

	▪ Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 2 support surfaces.
Payment Rules	A Group 2 support surface may be a **capped rental** or **purchase** depending on the specific HCPCS procedure code. A powered air flotation bed is a **rental only** and must be billed as a daily rate by reporting total number of days used as units. If the unit is billed as a capped rental, the rental payment would be inclusive of the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. For a powered air flotation bed, if use exceeds a ten-month time frame, report the "MS" modifier after six months of continued maintenance and servicing of the item. (MS - six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty)

2.42 Support Surfaces – Group 3 [Re-numbered 4/1/2025]

Definition	Pressure Reducing Support Surfaces – Group 3 are fully integrated air fluidized beds for the purpose of alleviating pressure. The surface uses the circulation of filtered air through silicone coated ceramic beads that creates the characteristics of fluid.
Standards of Coverage	A Group 3 air-fluidized bed is covered for up to 90 days if all of the following applies: ▪ The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure ulcer. ▪ The beneficiary is bedridden or chairbound as a result of severely limited mobility. ▪ The beneficiary's attending physician orders in writing an air-fluidized bed based on a comprehensive assessment and evaluation of the beneficiary after conservative treatment has been tried without success. ▪ A trained adult caregiver is available to assist the beneficiary with ADLs, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management of the air-fluidized bed. ▪ A physician directs the home treatment regimen and re-evaluates the need for the air-fluidized bed on a monthly basis. ▪ All other conservative treatment methods have been tried without success (e.g., Group 1 or Group 2 support surfaces).

	Continued Use of a Group 3 support surface - Continued use of a Group 3 support surface may be covered for restorative purposes only when healing continues to progress. Continued use of a Group 3 support surface will not be reauthorized for coverage if: ▪ Beneficiary is noncompliant with care plan; or ▪ Documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
Noncovered Support Services	Group 3 support surfaces are noncovered if: ▪ Beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material. ▪ Caregiver is unwilling or unable to provide the type of care required by the beneficiary on a air-fluidized bed. ▪ Structural support is inadequate to support the weight of the air-fluidized bed system. ▪ Electrical system is insufficient for the anticipated increase in energy consumption. ▪ Other known contraindications exist.
Documentation	Documentation must be less than 14 days old and include the following: ▪ Diagnosis/medical condition related to the need for the bed. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities already tried. ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Monthly assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 3 support surface requests.
Payment Rules	A Group 3 support surface or air fluidized bed is a **rental only** item and must be billed as a daily rate by reporting total number of days used as units. The rental payment is considered to include the following: ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. If use exceeds a 10-month timeframe, report the "MS" modifier after six months of continued maintenance and servicing of the item.

2.43 Surgical Dressings [Re-numbered 4/1/2025]

Definition	Surgical dressings include a primary dressing (used as a protective covering applied directly to the wound or lesion) and/or a secondary dressing (used to secure a primary dressing in place). Many of the primary dressings covered by MDHHS are self-adhesive and would not require a secondary dressing to be placed as well. Examples of surgical dressing are adhesive tape, roll gauze, and elastic bandages.
Standards of Coverage	Surgical dressings are covered for one or more of the following: ▪ To treat a wound or opening in the skin. ▪ To debride a wound or lesion. ▪ To treat pressure ulcers.
	Coverage of the quantity or type of dressing is based on: ▪ Size, stage, location and current status of the wound/lesions being treated. ▪ Number of wounds/lesions. ▪ Number of body locations involved. ▪ Frequency of dressing change.
Documentation	Documentation must be less than 30 days old and include the following: ▪ Diagnosis/medical condition related to the need for the items(s). ▪ Item to be dispensed. ▪ Quantity of item needed per dressing change. ▪ Anticipated frequency of dressing change. ▪ Size, stage, location, and number of wounds/lesions. For dressing requests of quantities over established limits, documentation to substantiate medical need is required.
PA Requirements	PA is required for: ▪ Collagen dressings or wound fillers. ▪ Silicone gel sheets. ▪ Composite dressings. ▪ Quantities beyond Medicaid's established limits.
	PA is not required for all other types of surgical dressings unless usage exceeds established quantity limitations.
Payment Rules	All items are considered a **purchase** up to the allowable quantities. Modifiers A1 through A9 must be reported in addition to the HCPCS code to report the appropriate number of wounds being treated. The modifiers are as follows: ▪ A1 - Dressing for one wound ▪ A2 – Dressing for two wounds ▪ A3 – Dressing for three wounds

	▪ A4 – Dressing for four wounds ▪ A5 – Dressing for five wounds ▪ A6 – Dressing for six wounds ▪ A7 – Dressing for seven wounds ▪ A8 – Dressing for eight wounds ▪ A9 – Dressing for nine or more wounds Dressings related to infusion pumps, parenteral/enteral nutrition, tracheostomy, or gastrostomy are included in either the daily rate or in established all-inclusive kit codes and are not separately reimbursable.

2.44 TRACHEOSTOMY CARE SUPPLIES [RE-NUMBERED 4/1/2025]

Definition	Tracheostomy care supplies include, but are not limited to, tracheostomy filters, tubes, masks, care kits, cleaning brushes, shower protectors and suction catheters.
Standards of Coverage	Tracheostomy care supplies are covered to support the care of a beneficiary with a tracheostomy. A tracheostomy starter kit may be covered for the four weeks following the initial tracheostomy surgery. The kit code includes the following items: Plastic tray, basin, sterile gloves, tube brush, pipe cleaners, a pre-cut tracheostomy dressing, a roll of gauze, drain sponges, cotton tip applicators, tracheostomy tube ties, or twill tape. After the initial four weeks, the established tracheostomy kit may be covered. The kit code includes the following items: Tube brush, pipe cleaners, cotton tip applicators, tracheostomy tube ties or twill tape, and drain sponges.
Documentation	Documentation must be less than 90 days old and include the following: ▪ Diagnosis/medical condition. ▪ Specific items required.
PA Requirements	PA is not required when the Standards of Coverage are met and established quantity limits are not exceeded.
	PA is required when: ▪ Standards of Coverage are not met. ▪ Quantities requested exceed the established limits. ▪ Other items not part of one of the kit codes may be considered for separate reimbursement. (Refer to the Medicaid Code and Rate Reference tool for additional information.)
Payment Rules	Payment is **purchase only**. All quantities reported should reflect a 30-day supply.

2.45 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR [RE-NUMBERED 4/1/2025]

Definition	A Transcutaneous Electrical Nerve Stimulator (TENS) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the beneficiary's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.

Standards of Coverage	A TENS unit is covered for reduction of pain for beneficiaries with either chronic, intractable pain of at least three months duration, or acute post-operative pain limited to 30 days from the date of surgery, or pain related to cancer, when: ▪ The beneficiary is able to use the TENS device. ▪ There is effective control of pain. ▪ Other treatment modalities have been ineffective.
Documentation	Documentation must be less than 30 days old and must include all of the following: ▪ Diagnosis/medical condition related to the need for a TENS (including type and location of pain). ▪ Alternative treatments for pain tried and the results. ▪ Other modalities of treatment still being used (type and duration must be detailed). For coverage beyond 90 days, include documentation addressing continued effective pain control.
	Continued Use after the initial 90 days - The documentation must be included with the PA request to describe the effectiveness of the treatment received. For continued coverage for chronic intractable pain, the documentation must be within 30 days and include the following: ▪ Medication regimen, before and after use. ▪ Functional level (affected by pain) before and after.
PA Requirements	PA is required for all requests.
Payment Rules	A TENS unit may be considered as a **capped rental**. The rental payment is inclusive of the following: ▪ All accessories needed to use the equipment (e.g., electrodes, lead wires, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.46 WALKERS [RE-NUMBERED 4/1/2025]

Definition	Walkers include, but are not limited to, rigid, wheeled, heavy duty, and folding.
Standards of Coverage	Walkers may be covered when the beneficiary has impaired ambulation and requires a walker for safe and independent ambulation.
Documentation	Documentation must be less than six months old and include: ▪ Diagnosis/medical condition related to the need for the service. ▪ Functional level possible with use of walker. ▪ Medical reason for type of attachment or modification, if applicable. ▪ Medical reason for heavy-duty walker (e.g., obesity, severe neurological disorder, or restricted use of hands). ▪ Duration of need and frequency of use. ▪ Identification of other specific economic alternatives ruled out. ▪ Identification of make, model, serial number, and warranty information. ▪ Statement of medical need for the specific walker requested. In addition, for each walker type, the following must be included: ▪ **Standard Walkers** ➢ Medical/functional reason a cane would not meet the beneficiary's ability to perform MRADL ▪ **Walker with Trunk Support** ➢ Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADL ▪ **Enclosed Walker with Posterior Seat** ➢ Medical/functional reason a standard walker would not meet the beneficiary's ability to perform MRADL ▪ **Heavy-Duty Walker** ➢ Medical/functional reason for a heavy-duty walker (e.g., obesity, severe neurological disorder, restricted use of hands)
PA Requirements	PA is not required for walkers if the Standards of Coverage and Documentation are met.
	PA is required for: ▪ Replacement within five years. ▪ Additional attachments (e.g., arm troughs). ▪ Replacement within five years for age 21 and over. ▪ Replacement within two years for under age 21.
Payment Rules	Walkers may be a **capped rental** or **purchase** item. After the first ten months of rental, necessary repairs and/or replacements of accessories are separately reimbursable.

2.47 Wearable Cardioverter-Defibrillators [Re-numbered 4/1/2025]

Definition	A wearable cardioverter-defibrillator (WCD) is an external device intended to perform the same tasks as an implantable cardioverter-defibrillator (ICD) without requiring an invasive procedure. It is considered a bridge to permanent ICD placement. The WCD consists of a vest, worn continuously underneath clothing, and contains cardiac monitoring electrodes that deliver a counter shock. The vest is connected to a monitor with a battery pack and alarm module that interprets the cardiac rhythm and determines when a counter shock is necessary. An alarm module alerts the patient to certain conditions by lights or voice messages.
Standards of Coverage	The WCD may be considered medically necessary only as an interim treatment for patients at high risk of sudden cardiac arrest who: ▪ Have a left ventricular ejection fraction of 35% or less; and ▪ Have a temporary contraindication to receiving an ICD (i.e., a systemic infection) at the current time; and ▪ Have experienced a documented episode of ventricular fibrillation or sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia that was not due to a transient or reversible cause and did not occur during the first 48 hours of an acute myocardial infarction; and ▪ Are tentatively scheduled for an ICD placement procedure based on one of the following: ➢ Received treatment with the goal of an ICD placement and have been scheduled for the ICD placement within three months; or ➢ Had an ICD removed and have been scheduled for placement of another ICD once the contraindication has been treated. WCDs will not be covered for investigational procedures or patient preference.
Documentation	Documentation must include the following and be made available upon request unless otherwise noted in the Standards of Coverage and PA Requirements sections of this policy: ▪ Diagnosis/medical condition related to the need for the item. ▪ Specific item(s) required. ▪ Medical reason why receiving an ICD is not currently plausible. ▪ Current treatment plan and updated recommendations. ▪ Tentative scheduled date for ICD placement and/or date other ICD removed. In addition to the above documentation requirements, for continued need beyond the initial 60-day approval period, compliance download data for the previous 60-day initial authorization period, or if submitting a prior authorization request 15 days prior to the end of the initial approval period; there must be a minimum of 45 days wear time download data.
PA Requirements	Food and Drug Administration (FDA)-registered WCDs are covered under the Medicaid and CSHCS programs with prior authorization (PA). Requests for PA (form MSA-1653-B) may only be submitted by the beneficiary's managing cardiologist and must include a current treatment plan and updated recommendations. PAs are approved for 60 days at a time for a maximum of four months.

	For continued medical need beyond the initial 60 days, a new PA request must be submitted documenting all of the following: ▪ The beneficiary's response to and continued need for the WCD; ▪ The anticipated date of the ICD procedure; and ▪ Documentation of the beneficiary's compliance with wearing the WCD. The compliance report should demonstrate a compliance rate of at least 92% for the previous 60-day period. The provider may submit an authorization request 15 days prior to the end of the initial approval period; however, there must be a minimum of 45 days wear time download data submitted with the authorization request. Requests for continued PA beyond the maximum of four months will be considered on a case-by-case basis. Subsequent approvals will be for month-to-month periods.
Payment Rules	WCDs are rental only items. The rental fee includes the vest, monitoring electrodes, therapy electrodes and batteries. The batteries, garments and electrodes may be replaced due to normal use and wear of the WCD and require PA.

2.48 Wheelchairs, Pediatric Mobility, and Seating Systems [Re-numbered 4/1/2025]

2.48.A. Definitions [Re-numbered & Changes Made 4/1/2025]

Wheelchair	A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc. Some wheelchairs are classified as CRT equipment. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website. (Refer to the Directory Appendix for website information.) **(text added per bulletin MMP 24-58)**
Pediatric Mobility Product	Pediatric mobility products are pediatric-sized mobility and wheelchair seating systems that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, specialized strollers, and wheelchair seating systems designed specifically for children with special needs. These products must meet the definition of Durable Medical Equipment (DME) (refer to the Program Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative. Refer to the Children's/Adolescent Products section of this chapter for other pediatric specific products. Some pediatric mobility products are classified as CRT equipment. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website. (Refer to the Directory Appendix for website information.) **(text added per bulletin MMP 24-58)**
Licensed Medical Professional	A licensed medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier. Medicaid policy requires that assessments must be performed by a licensed medical professional. A physical therapy assistant (PTA) or a licensed occupational therapy

	assistant (OTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656. CRT equipment and accessories require an evaluation by a QHCP. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information. **(text added per bulletin MMP 24-58)**
Pediatric Subspecialist	A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.
Institutional Residential Setting	An institutional residential setting refers to a nursing facility, State Veterans' Home, hospital long-term care unit, or county medical care facility.
Community Residential Setting	A community residential setting is defined as a non-institutional setting in the community, i.e., beneficiary's own home, Adult Foster Care (AFC), Assisted Living or Group Home.

2.48.B. Standards of Coverage [Re-numbered & Changes Made 4/1/2025]

Some wheelchairs, pediatric mobility and seating systems are classified as CRT equipment and may only be provided by a DME provider enrolled as a CRT provider. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection of this chapter and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website for additional information. (Refer to the Directory Appendix for website information.) All CRT equipment and accessories require prior approval. **(text added per bulletin MMP 24-58)**

Manual Wheelchair in Community Residential Setting	May be covered if **all** of the following are met: ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute with or without an assistive medical device. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury. ▪ Purchase of a wheelchair is required for long-term use (greater than 10 months). ▪ Must be able to use the wheelchair in the home environment (e.g., wheelchair must be able to fit through doorways and cross thresholds) ▪ Must identify other economic alternatives considered. ▪ Must have a method to propel wheelchair, which may include: ➢ Ability to self-propel for at least 60 feet over hard, smooth, or carpeted surfaces. ➢ The beneficiary has a willing and able caregiver to push the chair if needed. In addition: A **standard hemi-wheelchair** may be covered when a lower seat to the floor is required. A **standard light-weight wheelchair** may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance. A **heavy-duty standard wheelchair** may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. (Include patient's weight in the beneficiary's file.) An **extra heavy-duty standard wheelchair** is covered if the beneficiary's weight exceeds 300 pounds. (Include patient's weight in the beneficiary's file.) A **high-strength light-weight or ultra-light standard wheelchair** may be covered when required for a specific functional need. A **back-up or secondary standard manual wheelchair** may be considered when: ▪ The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.
Manual Wheelchair in Institutional Residential Setting	Coverage and reimbursement for all standard manual wheelchairs for an institutional residential setting is included in the per diem rate.

Manual Wheelchair with Custom-Fabricated Seating System in both Community Residential and Institutional Residential Settings	May be covered if **all** of the following are met, in addition to the Standards of Coverage listed under Manual Wheelchair in Community Residential Setting: ▪ Medical documentation provides a clinical assessment of the specific functional/clinical need for a custom-fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage. ▪ Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width. ▪ Is an integral part of the care regimen in the community residential setting or the daily nursing plan of care in an institutional residential setting.
Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings	May be covered if the beneficiary meets **all** of the following: ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals. ▪ Requires use of a wheelchair for at least four hours throughout the day. ▪ Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate. ▪ Has a cognitive, functional level that permits safe operation of a power mobility device with or without training. ▪ Has visual acuity that permits safe operation of a power mobility device. ▪ For a three-wheeled power mobility device, has sufficient trunk control and balance.
Pediatric Mobility Devices and Wheelchairs	May be covered if **all** of the following are met for each type of device. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries. **For manual pediatric wheelchairs**: ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without an assistive medical device or has a willing and able caregiver to push the chair **and** the wheelchair is required in a community residential setting. ▪ Is required for long-term use (greater than 10 months). ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. ▪ Is designed to be transportable. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs.

	For power wheelchairs: ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces (this includes the need to rest at intervals). ▪ Is able to safely control the wheelchair through doorways and over thresholds up to 1½". ▪ Has a cognitive, functional level that is adequate for power wheelchair mobility. ▪ Has visual acuity that permits safe operation of a power mobility device. ▪ Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width. ▪ For a three-wheeled power mobility device, has sufficient trunk control and balance. **For transport mobility medical devices (e.g., strollers)**: ▪ Is over three years of age or has a medical condition that cannot be accommodated by commercial products. ▪ Will be the primary mobility device due to inability to self-propel a manual wheelchair or operate a power wheelchair. ▪ Is required as a transport device when the primary wheelchair cannot be designed to be transportable. ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. ▪ Is required for use in the community residential setting.
Standard Seating System in Community Residential Setting	May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. May be covered if all of the following are met: ▪ Two or more of the above clinical indications are documented in the medical record and in the mobility assessment. ▪ Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width. ▪ Must document the reason for the selection when the system cannot be used in more than one mobility device. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

Custom-Fabricated Seating Systems	May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. May be covered if all of the following are met: ▪ Two or more of the above clinical indications are documented in the medical record and in the mobility assessment, and the severity of the clinical indications cannot be accommodated by a standard seating system. ▪ Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width. ▪ Must document the reason for the selection when the system cannot be used in more than one mobility device. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.
Manual or Power Recline Feature	May be covered when needed for relief of pressure on the seat and/or back, and **one** of the following applies: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Has ability to tolerate a 90-135 degree range of motion at the hip, needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved. A low shear recline back is covered when the beneficiary does not have the ability to reposition themselves in the wheelchair following reclining and the shearing would result in skin breakdown.
Manual Tilt-in-Space or Recline Function in Community Residential Setting	**Manual tilt-in-space** function allows the seat and back of the wheelchair to move as a unit, such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually.

	The **tilt-in-space** function for a wheelchair may be covered if **one or more** of the following apply: ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective. State reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and a custom-molded seating system. Coverage of both a **manual tilt-in-space and recline function** for a wheelchair requires medical need (such as high probability of the development of hip contractures) if only a tilt-in-space without recline is used. Also, there is a medical contraindication to using recline-only without the tilt-in-space function.
Power Tilt-in-Space or Recline Function in Both Community Residential and Institutional Residential Settings	**Power tilt-in-space or recline** function may be covered if **all** of the following exist: ▪ An existing medical condition results in the inability to reposition self without the use of a power tilt or recline mechanism. ▪ The frequency of repositioning is clinically indicated and is an integral part of the nursing facility plan of care. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and there are regular periods of time that the beneficiary is without assistance. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and is able to independently care for themself when provided a power tilt-in-space or recline modification. For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.
Wheelchair Accessories	Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific wheelchair accessory codes when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or an addition to an existing wheelchair if: ▪ It is required to provide safety. ▪ It is required for appropriate positioning. ▪ It is the most economical alternative. For additions to an existing wheelchair, the physician or the occupational or physical therapist must address the status/condition of the current wheelchair and include the brand, model, serial number, and age of the current wheelchair. If MDHHS did not purchase the wheelchair being modified, all documentation requirements must be provided as if the request is for a new or initial wheelchair. Refer to the Non-Covered Items section of this chapter for information on accessories that are not covered.

2.48.C. Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices [Re-numbered & Changes Made 4/1/2025]

Prior Authorization	The Medicaid Utilization Analyst (Program Review Division) is the authorized Medicaid representative who determines if the service requested falls within the standards of coverage. A prior authorization request may be returned or denied if the documentation is incomplete and not specific to the beneficiary and device requested. MDHHS reserves the right to request additional documentation to determine medical necessity. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries. For beneficiaries in the community residential setting, the decision notice is sent to the medical supplier with a copy to the beneficiary. For beneficiaries in the institutional residential setting, the decision notice is sent to the institutional residence with a copy to the beneficiary. Prior authorization is required for: ▪ Power wheelchairs, power-operated vehicles, seating, and accessories. ▪ New and replacement custom-fabricated seating systems, and the addition of functions for tilt-in-space and/or recline (power or manual). ▪ All CRT equipment and accessories. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)** ▪ Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items. ▪ Replacement of standard wheelchairs beyond established timeframes. Standard wheelchairs with specified accessories/add-ons do not require prior authorization if the Standards of Coverage and Documentation requirements are met. Consult the Medicaid Code and Rate Reference tool and the Wheelchair/Power-Operated Mobility Accessory Reimbursement document on the MDHHS website for accessories/add-on items that require prior authorization and/or are included in the wheelchair base. (Refer to the Directory Appendix for website information.)
Clinical Documentation	The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the evaluation was completed. Clinical documentation must include how the requested seating or mobility device is the most appropriate to assist in performing MRADL. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

Prior Authorization Exceptions	Prior authorization is **not** required for the following if standards of coverage are met: ▪ Specific accessory codes and/or repair codes. ▪ Specific pediatric mobility devices that do not include any accessories if the related diagnosis/condition is one of the following: ➢ Spinal Muscular Atrophy ➢ Motor Neuron Disease ➢ Anterior Horn Cell Disease, Unspecified ➢ Other Anterior Horn Cell Disease ➢ Hemiplegia and Hemiparesis ➢ Infantile Cerebral Palsy ➢ Myoneural Disorders, Unspecified ➢ Other Specified Myoneural Disorders ➢ Spina Bifida with Hydrocephalus ➢ Spina Bifida without Mention of Hydrocephalus ➢ Spina Bifida (Other Congenital Anomalies of Nervous System) ➢ Microcephalus ➢ Reduction Deformities of Brain ➢ Congenital Hydrocephalus ➢ Muscular Dystrophies and Other Myopathies NOTE: All CRT equipment and accessories require PA regardless of diagnosis. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) **(text added per bulletin MMP 24-58)** NOTE: If prior authorization is required for any component of the mobility device (including accessories), then PA is required for the device as well. For example, if a custom-fabricated seating system is required, then prior authorization for the pediatric mobility device is also required.
Rentals, Repairs and Replacement	A wheelchair can be considered a **capped rental** or a **purchase** item. **Repairs** Labor (K0739): MDHHS developed a Wheelchair Repair/Labor Guide for providers to use to determine the maximum allowed number of units of labor for repairs to wheelchairs using replacement parts/accessories with identified HCPCS codes. The guide is posted on the Provider Specific (Medical Supplier) page of the MDHHS website. (Refer to the Directory Appendix for website information.) To request labor, report HCPCS code K0739 and the total number of units on the prior authorization request. Providers may request no more than the allowable number of labor units listed in the Wheelchair Repair/Labor Guide for each replacement part regardless of actual repair time. All repairs include screws, nuts and bolts unless otherwise stipulated in the Guide.

	Labor associated with the removal of the original component part, replacement with a new component, and finishing is included in the total number of labor units indicated in the Wheelchair Repair/Labor Guide. All costs to repair the wheelchair must be included on the PA request, including cost for parts and labor. The estimated cost to repair versus replace the wheelchair must be included on the PA request when requesting repairs using multiple component parts/accessories. <u>Beneficiary-owned and purchased by MDHHS:</u> ▪ Covered only after the manufacturer's warranty has been exhausted. ▪ If the DME provider is the same provider that originally supplied the wheelchair, a new certificate of medical necessity (CMN) and/or physician's order is not necessary. ▪ The treating physician or the DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s). ▪ The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file. <u>MDHHS did not purchase the original wheelchair:</u> ▪ Covered only after the manufacturer's warranty has expired. ▪ Requires a new physician order, CMN, and required documentation indicated in the wheelchair and repair policies must be completed and submitted with the PA request. ▪ The DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s). ▪ The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. MDHHS will not pay for repairs to parts/accessories that are not typically covered by Medicaid or that were not approved for the initial purchase of the wheelchair/accessory. The repair of a second (older) manual or power wheelchair used as a back-up wheelchair is not covered. Routine cleaning of wheelchairs or parts is not covered. MDHHS does not reimburse for labor and repairs: ▪ For initial purchases; ▪ During rental periods; or ▪ For items under warranty. Refer to the Repairs and Replacement Parts subsection of this chapter for further repair policy.

	Replacement of a mobility device is subject to the manufacturer's warranty and/or cost of repairs. The replacement may also be considered when a significant change in the beneficiary's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children. Medicaid will not authorize coverage of replacement of any DME item or accessory that is requested solely because new technology is available. Replacement or modifications must be medically necessary and required as a result of a change in the medical condition that makes the covered service unusable or contraindicated.
Prior Authorization Process for Beneficiaries in the Community Residential Setting	The prior authorization process for beneficiaries in the community residential setting is initiated by the treating physician's written order for a seating/mobility evaluation that includes the reason for the referral. The evaluation must be completed by a licensed medical professional using the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656). (Refer to the Prior Authorization Form subsection and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection of this chapter for additional information.)
Prior Authorization Process for Beneficiaries in the Institutional Residential Setting	Prior authorization is required for Medicaid coverage and separate reimbursement for medically necessary power-operated vehicles and power or manual wheelchairs with custom-fabricated seating systems. The request for a resident assessment must be initiated by the treating physician with the stated medical reason for the referral. Facility clinicians who are responsible for the overall nursing plan of care and treatment of the resident will prepare and submit prior authorization requests and medical documentation directly to the MDHHS Program Review Division. Refer to the Nursing Facility Coverages chapter for additional information regarding prior authorization of wheelchairs and custom-fabricated seating systems for beneficiaries in an institutional residential setting. (Refer to the Prior Authorization Form subsection and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection of this chapter for additional information.)

2.49 VENTILATORS [RE-NUMBERED 4/1/2025]

Definition	A ventilator is a device designed to intermittently or continuously assist or control pulmonary ventilation. ▪ A negative pressure ventilator exerts negative (subatmospheric) pressure on the exterior chest wall. ▪ A positive pressure ventilator ventilates the lungs as the result of a positive pressure applied to the airway.
Standards of Coverage	Negative and positive pressure ventilators may be covered when there is a respiratory related diagnosis (e.g., neuromuscular disease, thoracic restrictive disease, chronic respiratory failure) and the beneficiary requires ventilator assistance.

Documentation	Documentation must be less than 90 days old and include the following: ▪ Respiratory diagnosis/medical condition related to the need for the ventilator. ▪ Type of ventilator ordered. ▪ Ventilator settings. ▪ Number of hours beneficiary is required to use the ventilator.
PA Requirements	PA is required for all ventilators.
Payment Rules	All ventilators are a **rental only** item and are inclusive of the following: ▪ All accessories needed to use the unit (e.g., circuits, water feed sets, adaptors, temperature probes, filters, heated or nonheated humidifier, oxygen analyzer, water or saline for humidifier, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. An additional ventilator may only be covered to allow a beneficiary access to the community. When billing more than one vent, the additional vent must be reported using a NOC code. A backup ventilator in case of a power failure is not separately reimbursable.

MI Choice Waiver

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SECTION 1 – GENERAL INFORMATION

MI Choice is a waiver program operated by the Michigan Department of Health and Human Services (MDHHS) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under sections 1915(b) and 1915(c) of the Social Security Act. MDHHS carries out its waiver obligations through a network of enrolled providers that operate as Prepaid Ambulatory Health Plans (PAHPs). These entities are commonly referred to as waiver agencies. MDHHS and its waiver agencies must abide by the terms and conditions set forth in the approved waivers.

MI Choice services are available to qualified participants throughout the state, and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. MDHHS will not enact any provision to the MI Choice program that prohibits or inhibits a participant's access to a person-centered service plan, discourages participant direction of services, interferes with a participant's right to have grievances and complaints heard, or endangers the health and welfare of a participant. The program must monitor and actively seek to improve the quality of services delivered to participants. Safeguards are utilized to ensure the integrity of payments for waiver services and the adequacy of systems to maintain compliance with federal requirements.

Waiver agencies are required to provide oral and written assistance to all Limited English Proficient applicants and participants. Agencies must arrange for translated materials to be accessible or make such information available orally through bilingual staff or the use of interpreters.

SECTION 2 – ELIGIBILITY

The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities age 18 or older and meet the following eligibility criteria:

- An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
- Must be categorically eligible for Medicaid as aged or disabled.
- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- It must be established that the applicant requires at least two waiver services, one of which must be supports coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

2.1 FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by MDHHS. As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is available to participants in the special home and community-based group under 42 CFR §435.217 with a special income level up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice.

To initiate a financial eligibility determination, MI Choice waiver agencies must enter enrollment notifications electronically in the Community Health Automated Medicaid Processing System (CHAMPS). Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. MI Choice waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record.

2.2 FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify an applicant's functional eligibility for program enrollment using the LOCD application in CHAMPS. Waiver agencies must conduct an LOCD in person with an applicant and submit that information in the LOCD application in CHAMPS, or the agency may adopt an existing LOCD conducted by another provider. The information submitted is put through an algorithm within the application to determine whether the applicant meets LOCD criteria. Only the LOCD application in CHAMPS can determine functional eligibility for the nursing facility level of care. Additional information can be found in the Nursing Facility Level of Care Determination Chapter and is applicable to MI Choice applicants and participants.

2.2.A. Freedom of Choice

Prior to MI Choice enrollment, all applicants and their legal representatives must be given information regarding all Medicaid long-term services and supports options for which they qualify through the LOCD, including MI Choice, Nursing Facility, MI Health Link, and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE, MI Choice, MI Health Link, and Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options through the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record and a copy provided to the applicant or participant upon request. Additional information can be found in the Nursing Facility Level of Care Determination Chapter.

The FOC form must be completed with each conducted LOCD and any time an LOCD is adopted. Waiver agencies must make a considerable effort to obtain all necessary signatures. If the waiver agency is unable to obtain signatures from the beneficiary, or their representative, the attempts to get signatures must be documented. While informing the beneficiary of available choices for the receipt of long-term services and supports is the main reason for the FOC form, this form also serves to verify that the waiver agency conducted an LOCD. Should there be any issues with the LOCD being uploaded and saved in CHAMPS, the FOC form will provide verification that the LOCD was conducted and whether the beneficiary met LOCD.

2.3 Need for MI Choice Services

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of two covered services, one of which must be supports coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to receive MI Choice services on a regular basis, at least every 30 days.

An applicant cannot be enrolled in MI Choice if their service and support needs can be fully met through the intervention of State Plan or other available Medicaid services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications.

2.4 Excluded from Eligibility

The MI Choice population specifically excludes the following groups:

- Medicaid-eligible persons who reside in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) or a state psychiatric hospital,

- Medicaid-eligible persons enrolled in a qualified health plan (e.g., health maintenance organization) or managed care organization,
- Persons enrolled in PACE,
- Persons enrolled in the Habilitation Supports Waiver program,
- Persons enrolled in the MI Health Link program,
- Persons enrolled in the Home Help Services program whose service and support needs are fully met by that program,
- Persons enrolled in the Healthy Michigan Plan,
- Nursing facility residents, and
- Medicaid-eligible persons admitted to a hospice or palliative care facility.

SECTION 3 – ENROLLMENT

MI Choice waiver agencies determine the enrollment dates upon MDHHS financial eligibility verification, and termination dates for each participant for whom they provide waiver services. No applicant shall be granted enrollment status without fully meeting all eligibility requirements. MI Choice applicants require at least two waiver services on a continual basis, one of which must be supports coordination, in order to be enrolled in MI Choice. When a potentially eligible applicant cannot be enrolled due to the waiver agency being at capacity, the applicant is placed on a waiting list. Refer to the Waiting Lists subsection for additional information. MDHHS reviews and provides final approval for determinations that result in enrollment, denials or terminations for MI Choice.

3.1 GENERAL PROVISIONS OF PARTICIPATION

There are a number of circumstances that play a role in the eligibility status of MI Choice participants. The following subsections define these impacts.

3.1.A. ENROLLMENT IN OTHER PROGRAMS AND PROGRAM ENROLLMENT TYPES

A program participant cannot be simultaneously enrolled in both MI Choice and a Medicaid Health Plan, PACE, MI Health Link, or any other §1915(c) waiver program. Applicants must choose one program in which they wish to enroll. It is not necessary to either delay MI Choice enrollment or withhold MI Choice services pending the disenrollment process from any of the Medicaid Health Plans, but some programs require the individual to enroll on the first day of the month and disenroll only on the last day of the month. Enrollment and disenrollment policies for other programs must be followed to determine when to enroll someone in MI Choice.

Waiver agencies submit enrollment information directly to CHAMPS and CHAMPS will assign the appropriate MI Choice PET code once all information required is verified.

3.1.A.1. HOSPICE ENROLLMENT

A participant in the MI Choice program may receive Hospice services simultaneously when in a home and community-based setting. The individual must not be residing in a nursing facility or hospice residential facility while receiving MI Choice services. Individuals who are enrolled in both MI Choice and Hospice will have a PET code indicating this. For additional information regarding Hospice services, refer to the Hospice Chapter of this Manual. Participants who receive both MI Choice and Hospice or Palliative Care services must have a coordinated person-centered plan (PCP). MDHHS may employ a post-payment review to monitor services. If MDHHS finds that inappropriate (i.e., duplicative) services were authorized, MDHHS will seek recovery of Medicaid funds paid for duplicative services from the waiver agency.

3.1.A.2. Medicaid Qualified Health Plans (QHP)

An applicant enrolled in a Medicaid Qualified Health Plan (QHP) must choose between MI Choice services or the QHP. A Medicaid recipient cannot receive MI Choice services and enroll in the Medicaid QHP. When an applicant chooses MI Choice, the waiver agency will enter MI Choice enrollment information directly in CHAMPS.

3.1.A.3. Nursing Facility Admissions

When a MI Choice participant is admitted to a nursing facility from MI Choice, the waiver agency will enter the MI Choice disenrollment information in CHAMPS. The MI Choice end date will be the day before the nursing facility admission. Waiver agencies are encouraged to verify nursing facility admission dates with the nursing facility. When a previous MI Choice participant is discharged from the nursing facility, the waiver agency may reenroll the participant on the day of the nursing facility discharge through the enrollment process in CHAMPS. This change does not affect the LOCD requirements.

3.1.A.4. Hospital Admissions

A hospital admission is not an enrollment in a Benefit Plan or PET. Generally, waiver agencies do not provide MI Choice services, other than supports coordination (SC) and possibly continuation of a personal emergency response system (PERS), to participants while hospitalized.

A MI Choice participant admitted to a hospital may remain enrolled in MI Choice for up to 30 days. The waiver agency must provide the participant with an adverse benefit determination upon notification of a hospitalization if it is necessary for the agency to suspend MI Choice services during the hospitalization. When the participant is hospitalized for less than 30 days, the participant's services may restart upon discharge from the hospital. If the participant is discharged after 30 days, the participant may re-enroll in MI Choice using standard enrollment procedures. If a participant is admitted to a nursing facility from a hospital before the 30th day of hospital stay, the last MI Choice eligibility date is the day before the date of nursing facility admission.

3.1.A.5. Enrollment in MI Health Link

Individuals enrolled in MI Health Link cannot also enroll in MI Choice. Individuals should be referred to a Medicare/Medicaid Assistance Program counselor for options counseling before deciding to opt-out or disenroll from MI Health Link. Michigan ENROLLS handles all enrollments, disenrollments and opt-outs for MI Health Link. All MI Health Link disenrollments are effective on the last day of a month. Normally, this is the last day of the month of the request. For requests made later in the month, the disenrollment may not take effect until the last day of the month following the month of the request. Eligible individuals may enroll in MI Choice after the effective date of the MI Health Link disenrollment.

MI Health Link has nine PET codes depending upon the living arrangement of the individual.

Waiver agencies will need to coordinate enrollments with the MI Health Link discharge to ensure the proper MI Choice PET sets on the day of MI Choice enrollment. MI Health Link discharges will be effective on the last day of the month. Therefore, MI Choice must not enroll until the first day of the following month.

3.1.B. Institutional Stays

There are occasions when a MI Choice participant requires a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of MI Choice waiver services during the hospital stay to avoid duplication of services from the hospital and MI Choice; however, the participant may remain enrolled in MI Choice. A participant who is hospitalized for more than 30 consecutive days must be disenrolled.

A participant admitted to a nursing facility for rehabilitation services or for any reason other than an approved short-term out-of-home respite stay must be disenrolled from MI Choice on the date prior to the nursing facility admission. The individual may be re-enrolled into MI Choice upon discharge from the nursing facility as long as the individual meets eligibility criteria as described in the Eligibility section of this chapter.

3.2 MI Choice Intake Guidelines

The MI Choice Intake Guidelines (MIG) is a list of questions designed to screen applicants for eligibility and further assessment. Additional probative questions are permissible when needed to clarify eligibility. The MIG does not, in itself, establish program eligibility. A properly completed MIG is mandatory for MI Choice waiver agencies prior to placing applicants on a MI Choice waiting list when the waiver agency is operating at its capacity. Individuals who score as Level C, Level D, Level D1 or Level E are those applicants determined potentially eligible for program enrollment and will be placed on the waiver agency's MI Choice waiting list. The date of the MIG contact establishes the chronological placement of the applicant on the waiting list. The MIG may be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

When the waiver agency is at capacity, applicants requesting enrollment in MI Choice must either be screened by telephone or in person using the MIG at the time of their request for proper placement on the waiting list. If a caller is seeking services for another individual, the waiver agency will either contact the applicant for whom services are being requested or complete the MIG to the extent possible using information known to the caller. For applicants who are deaf, hearing impaired, or otherwise unable to participate in a telephone interview, the waiver agency must use the applicant's preferred means of communication. It is acceptable to use an interpreter, a third-party in the interview, or assistive technology to facilitate the exchange of information.

As a rule, nursing facility residents who are seeking to transition into MI Choice are not contacted by telephone but rather are interviewed in the nursing facility. For the purposes of establishing a point of reference for the waiting list, the date of the initial nursing facility visit (introductory interview) shall be considered the same as conducting a MIG, so long as the functional objectives of the MIG are met.

(Refer to the Waiting Lists subsection of this chapter for additional information.) Specifically, the introductory meeting must establish a reasonable expectation that the applicant will meet the functional and financial eligibility requirements of the MI Choice program within the next 60 days.

Applicants who are expected to be ineligible based on MIG information may request a face-to-face evaluation using the LOCD and financial eligibility criteria. Such evaluations should be conducted as soon as possible, but must be done within 10 business days of the date the MI Choice Intake Guidelines was administered. MI Choice waiver agencies must issue an adverse action notice advising applicants of any and all appeal rights when the applicant appears ineligible either through the MIG or a face-to-face evaluation.

When an applicant appears to be functionally eligible based on the MIG but is not expected to meet the financial eligibility requirements, the MI Choice waiver agency must place the applicant on the waiting list if it is anticipated that the applicant will become financially eligible within 60 days.

The MIG is the only recognized tool accepted for telephonic screening of MI Choice applicants and is only accessible to MI Choice waiver agencies. It is not intended to be used for any other purpose within the MI Choice program, nor any other Medicaid program. MI Choice waiver agencies must collect MI Choice Intake Guidelines data electronically using software through the MDHHS contracted vendor.

3.3 Enrollment Capacity

MI Choice capacity is limited to a maximum number of participants served at any point in the fiscal year as specified in the approved waiver application. Waiver agencies are allocated a specific number of slots each fiscal year and are responsible for managing enrollment so as not to exceed the maximum number of participants served at any point in the fiscal year. MDHHS reserves the right to reallocate slots as necessary to best meet MI Choice program demands.

3.4 Waiting Lists

Whenever the number of participants receiving services through MI Choice exceeds the existing program capacity, any screened applicant must be placed on the MI Choice waiting list. The waiting list must be actively maintained and managed by each MI Choice waiver agency. The enrollment process for the MI Choice program is not ever actually or constructively closed. The applicant's place on the waiting list is determined by priority category in the order described below. Within each category, an applicant is placed on the list in chronological order based on the date of their request for services. This is the only approved method of accessing waiver services when the waiver program is at capacity.

3.4.A. Priority Categories

Applicants will be placed on the waiting list by priority category and then chronologically by date of request of services. Enrollment in MI Choice is assigned on a first-come/first-served basis using the following categories, listed in order of priority given.

Waiver agencies are required to conduct follow-up phone calls to all applicants on the waiting list. The calls are to determine the applicant's status, offer assistance in accessing alternative services, identify applicants who should be removed from the list, and identify applicants who might be in crisis or at imminent risk of admission to a nursing facility. Each applicant on the waiting list is to be contacted at least once every

90 days. Applicants in crisis or at risk require more frequent contacts. Each waiver agency is required to maintain a record of these follow-up contacts.

3.4.A.1. State Plan Private Duty Nursing Age Expirations

This category includes only those applicants who continue to require Private Duty Nursing services at the time such coverage ends due to age restrictions.

3.4.A.2. Nursing Facility Transitions

Nursing facility residents who desire to transition to the community and will otherwise meet enrollment requirements for MI Choice qualify for this priority status. Priority status is not given to applicants whose service and support needs can be fully met by existing State Plan services.

3.4.A.3. Adult Protective Services (APS) and Diversions

An applicant with an active Adult Protective Services (APS) case is given priority when critical needs can be addressed by MI Choice services. It is not expected that MI Choice waiver agencies solicit APS cases, but priority is given when necessary.

An applicant is eligible for diversion priority if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission. Imminent risk of placement in a nursing facility is determined using the Imminent Risk Assessment (IRA), an evaluation developed by MDHHS. Use of the IRA is essential in providing an objective differentiation between those applicants at risk of a nursing facility placement and those at imminent risk of such a placement. Only applicants found to meet the standard of imminent risk are given priority status on the waiting list. Applicants may request that a subsequent IRA be performed upon a change of condition or circumstance.

Supports coordinators must administer the IRA in person. The design of the tool makes telephone contact insufficient to make a valid determination. Waiver agencies must submit a request for diversion status for an applicant to MDHHS. (Refer to the Directory Appendix for details.) A final approval of a diversion request is made by MDHHS.

3.4.A.4. Chronological Order by Service Request Date

This category includes applicants who do not meet any of the above priority categories or for whom prioritizing information is not known. As stated, applicants will be placed on the waiting list in the chronological order that they requested services as documented by the date of MIG completion or the initial nursing facility introductory meeting.

3.4.B. Removing Applicants from Waiting List

Each waiver agency must follow these waiting list removal guidelines when removing an applicant from the MI Choice waiting list. A MI Choice waiver agency may remove an applicant from the MI Choice waiting list if the applicant:

- Enrolled in MI Choice;
- Enrolled in another community-based service or program and that program is meeting the individual's needs;
- Was admitted to a nursing facility and is no longer interested in MI Choice;
- Is deceased;
- Moved out of state;
- Is not eligible for MI Choice;
- Is no longer interested in or refuses MI Choice enrollment; or
- Is unable to be contacted by the waiver agency using all of the following methods:
  - The waiver agency called at least three times with a varied day of week and time of day.
  - If the waiver agency was able to leave a message, and the applicant did not return the call within 10 business days.
  - The waiver agency sent a letter to the applicant with a deadline to contact the waiver agency within 12 business days, and the applicant either did not respond or mail was returned.

An Adequate Action Notice must be sent to the applicant no later than the date of removal from the MI Choice waiting list. MI Choice waiver agencies can obtain a template for the Adequate Action Notice on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.5 Enrollment Slots

CMS approves a given number of enrollment slots for the MI Choice program in the waiver application process. A slot consists of the enrollment of a participant for the duration of the fiscal year or, in other words, the total number of slots used is an unduplicated count of participants for the fiscal year. Therefore, a participant who might be enrolled and disenrolled from MI Choice numerous times throughout a given fiscal year utilizes only a single slot. Similarly, a participant might be disenrolled from the program at any given time, yet continues to occupy a slot until the conclusion of the fiscal year. It is an important distinction between that which constitutes enrollment and what is counted as a slot. Having a slot does not infer current enrollment.

3.6 Enrollment in MI Choice

After eligibility is determined, waiver agencies manage applicant enrollment into MI Choice. Waiver agencies develop written procedures for managing enrollment activities that are consistent with MDHHS policy.

3.6.A. First Day of Enrollment

The waiver agency establishes MI Choice enrollment and termination dates. The waiver agency is responsible for providing written notification to the MDHHS Field Office of these dates (refer to the Bridges Eligibility Manual, number 106); the MDHHS Field Office will

confirm eligibility for the dates specified. The waiver agency must enter enrollment and disenrollment information directly in CHAMPS. CHAMPS will then notify the MDHHS Field Office of the enrollment and disenrollment dates and will update other systems as necessary. The MI Choice enrollment date is on or following the assessment date. The enrollment date usually coincides with the date of assessment. However, the following situations may delay enrollment for a MI Choice participant:

- The waiver agency assesses an applicant in a nursing facility or hospital, or the applicant has another Medicaid PET code assigned at the time of the assessment.
  - On a date following assessment, the applicant returns home, to the community, or terminates participation in the other Medicaid program. MI Choice enrollment may begin only after the individual returns home or terminates participation in the other program.
  - Waiver agencies coordinate with the MDHHS Field Office or the other program to ensure termination from the other program before enrolling the participant in MI Choice. As a reminder, individuals transferring from MI Health Link, PACE, or the Habilitation Supports Waiver may only do so on the first of the month. Waiver agencies submit enrollment information in CHAMPS.
  - The waiver agency establishes the applicant's enrollment date on a date following discharge from the nursing facility, hospital, or other program. MI Choice enrollments can occur on the day of discharge from the nursing facility or hospital. The enrollment date must not be the assessment date when the individual was assessed while in the nursing facility or hospital unless the assessment date was the day of discharge from the nursing facility or hospital.
- An applicant is hospitalized after the waiver agency conducts an assessment. The waiver agency must delay establishing the enrollment date until after the applicant is discharged from the hospital.
- The applicant currently participates in the Home Help Services program. The waiver agency verifies and documents that the Home Help Services program no longer meets the service and support needs of the applicant. Waiver agencies may only make this determination through an in-home assessment and evaluation of the applicant. Waiver agencies MAY NOT require the individual to request and have additional Home Help Services benefits denied before making this determination.
  - The waiver agency requests termination of the Home Help Services program before MI Choice enrollment and asks the applicant to notify the MDHHS Field Office of this decision to terminate the Home Help Services program enrollment.
  - Participants are entitled to receive State Plan services while in MI Choice; however, MI Choice will meet all personal care needs so that the individual does not require Home Help Services when enrolled in MI Choice. The supports coordinators (SCs) should fully explain this choice to applicants requesting to switch from the Home Help Services program to MI Choice.
- An applicant is assessed at the end of a month. The waiver agency, with approval from the applicant, may establish the MI Choice enrollment date on the first day of the following month.

- The waiver agency assesses the applicant and determines the applicant meets LOCD criteria but has excess assets. The waiver agency shall delay enrollment into MI Choice until the MDHHS Field Office determines the applicant financially eligible.
- The applicant is enrolled in another managed long term services and supports (LTSS) program, including MI Health Link, PACE and Habilitation Supports Waiver, at the time of assessment. These are managed care programs where disenrollment is effective at the end of the month. The waiver agency will have to coordinate the MI Choice enrollment date to be the first day of the month after the effective date of the MI Health Link, PACE or Habilitation Supports Waiver disenrollment.
- The applicant does not have Medicaid at the time of assessment. Before the waiver agency can presume the applicant eligible for MI Choice, the applicant must submit a Medicaid application to the MDHHS Field Office. The waiver agency has several choices once the Medicaid application is in the approval process.
    - Do not enroll until Medicaid eligibility is confirmed. The waiver agency may wait to determine the MI Choice enrollment date. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility. This means the applicant has been approved for the waiver. The waiver agency will not enroll the applicant in MI Choice until the MDHHS Field Office confirms Medicaid eligibility. The waiver agency should not enter enrollment information into CHAMPS until Medicaid eligibility is determined and the enrollment date is verified. MI Choice enrollment occurs when all eligibility criteria has been confirmed and the waiver agency starts providing MI Choice services. In this situation, the first date of MI Choice enrollment cannot be sooner than the date the MDHHS Field Office confirms Medicaid eligibility, regardless of any retroactive Medicaid eligibility dates. It may be necessary to complete an additional LOCD or interRAI Home Care (iHC) assessment depending on the length of time it takes the MDHHS Field Office to make this determination. The waiver agency cannot assign the applicant a status of Waiver/Pending or Waiver/Yes from the date of assessment to the date of Medicaid eligibility confirmation. The applicant may have an eligibility status of Waiver/Ineligible or Waiver Financially Ineligible while waiting for the Medicaid confirmation.
    - Presume eligible and MDHHS confirms Medicaid eligibility. The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility, and has determined the applicant "approved" for the waiver. The waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. The waiver agency implements the full array of services identified in the applicants' person-centered service plan (PCSP) and proceeds as if the applicant met all eligibility criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. Once the MDHHS Field Office confirms Medicaid eligibility, the waiver agency may change the Waiver/Pending status to Waiver/Yes as of the date of the initial assessment or the first day of Medicaid eligibility, whichever is later. If the first day of Medicaid eligibility is later than the initial assessment date, the waiver agency

reclassifies the days from the initial assessment date to the first date of Medicaid eligibility to Waiver/Ineligible in the status tables. The waiver agency will need to notify MDHHS Home and Community Based Services Staff to correct the initial MI Choice enrollment date in CHAMPS.

- Presume eligible, but MDHHS denies Medicaid eligibility. The waiver agency may presume the MDHHS Field Office will approve the applicant's Medicaid application. The waiver agency notifies the MDHHS Field Office that it has assessed the applicant and determined the applicant meets all eligibility criteria, except Medicaid eligibility, and has determined the applicant "approved" for the waiver. The waiver agency implements the full array of services identified in the applicant's PCSP and proceeds as if the applicant met all eligibility criteria. In this situation, the waiver agency may assign a status of Waiver/Pending to the applicant. The waiver agency may enter the MI Choice enrollment date in CHAMPS. The MI Choice PET will set once CHAMPS is able to verify Medicaid eligibility via data transfers from Bridges. Once the MDHHS Field Office denies Medicaid eligibility, the waiver agency must change the Waiver/Pending status to Waiver/Ineligible as of the date of the initial assessment. The waiver agency will need to notify MDHHS Home and Community Based Services Staff to delete the MI Choice enrollment date in CHAMPS.

3.7 MI Choice Enrollment Notification to the MDHHS Field Office

The waiver agency notifies the MDHHS Field Office of MI Choice participant enrollment and disenrollment dates, as well as subsequent changes made to MI Choice enrollment and disenrollment dates. Waiver agencies are required to do the following:

- Waiver agencies must enter all enrollments in CHAMPS. Waiver agencies must enter enrollments in CHAMPS within five business days of knowing and verifying the actual date of enrollment. If the enrollment date changes, the waiver agency must contact the appropriate MDHHS staff to make a correction.
- Waiver agencies must enter all participant disenrollments in CHAMPS within five business days of knowing and verifying the actual disenrollment date. The MI Choice end date is the last day of the participant's enrollment in MI Choice.
- When the waiver agency needs to change a previously reported MI Choice start (enrollment) or stop (disenrollment) date, the waiver agency must notify MDHHS staff of the new date and the reason for altering the original date.
- The participant's record must clearly identify all enrollment and disenrollment dates for MI Choice participants.
- Waiver agencies must develop processes for confirming PET enrollment and disenrollment dates and verifying these dates correspond with Waiver/Yes dates in their Health Information Systems.

3.8 Participant Classification and Status Type

Most waiver agencies have more than one funding source for services provided by the agency. Waiver agencies utilize the COMPASS system, or a compatible data system, to track several types of care management programs. Waiver agencies assign a Program Classification Type to participant data records to permit accuracy in reporting and to avoid unnecessary duplication of participant counts within various

Medicaid and non-Medicaid funded LTSS programs. Restrictions in PET coding and MI Choice program eligibility may make it necessary to change a participant's program classification among care management program types.

3.8.A. Participant Program Classifications

The following participant program classifications are used in Michigan's Data Warehouse Database:

WA = Waiver

The participant is or is expected to be eligible for and enrolled in MI Choice.

Waiver Eligible Status Classifications

Y (Yes)	The participant meets LOCD criteria, the MDHHS Field Office determined financial eligibility, the participant requires at least one MI Choice service in addition to supports coordination, and the participant agrees to enroll in MI Choice. The participant must not be residing in a nursing facility or hospital for this classification.
N (No)	The participant is not enrolled in or does not qualify for MI Choice.
P (Pending)	The participant meets NFLOC and requires at least one MI Choice service in addition to supports coordination, but the waiver agency is awaiting confirmation of financial eligibility from the MDHHS Field Office. Waiver agencies can use the "Pending" status only when the Medicaid application has been completed and submitted to the MDHHS Field Office, and the waiver agency has preliminarily determined (presumed) the participant is likely to meet financial eligibility requirements.
I (Ineligible)	The participant did not meet at least one of the eligibility criteria for MI Choice.

Transition/Diversion Case Status

No	The participant was not transitioned from the nursing facility.
Diverted	The participant met Imminent Risk Criteria as approved by MDHHS in the Community Transition Services Portal and has enrolled in the MI Choice program.
Transitioned	The waiver agency submitted and MDHHS approved the appropriate information in the Community Transition Services Portal, the participant transitioned from a nursing facility, and the participant has enrolled in the MI Choice program.

Self-Determination (SD)

Yes	Indicates the participant is enrolled in the MI Choice program and has chosen the self-determination option for delivery of services.
No	Indicates the participant has not chosen the self-determination option for the delivery of services.

Memorandum of Understanding (MOU)/Special Memorandum of Understanding (SMOU)

No	Indicates the participant does not qualify for a MOU or a SMOU.
SMOU	Indicates this person meets the significant support participant criteria for the purposes of capitation rates as specified in Attachment Q of the MI Choice Contract.

Case or Open Status Classifications

A	Indicates the participant is on open maintenance status.
0	Indicates the participant is on open active status.

Requirements:

- The waiver agency is responsible for confirming participant case classifications for program participants and to monitor the accuracy of participant data records.
- Waiver agencies must track MI Choice eligibility dates and statuses accurately in MI Choice Information System (MICIS), COMPASS, or a compatible database.
- Participants have one program classification, eligibility, transition, self-determination, and case status classification during a single duration of time, with the exception of individuals who are in the process of transitioning from the nursing facility, and are expected to enroll in MI Choice.
- Waiver agencies have written procedures to establish program status for MI Choice participants and to maintain and monitor the accuracy of participant data records.
- When a waiver agency uses "Pending" waiver eligible status classification, the waiver agency must provide the participant with the full array of MI Choice services as specified in the PCSP. When the MDHHS Field Office confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the MI Choice assessment date or the start date of MI Choice services when the MDHHS Field Office grants Medicaid eligibility retroactive to the assessment date. If Medicaid eligibility begins after the assessment date, the waiver agency must use the first date of Medicaid eligibility as the start date of "Yes" waiver eligibility status.
- When the waiver agency is unable to presume financial eligibility for the participant, the agency must use the "Ineligible" waiver eligibility status classification. The waiver agency cannot begin MI Choice services until it receives confirmation from the MDHHS Field Office of the participant's eligibility for Medicaid. When the MDHHS Field Office confirms the participant's eligibility for Medicaid, the waiver agency may then reclassify the participant with "Yes" waiver eligibility status. The waiver agency may choose to begin the "Yes" waiver eligibility status from either the date of the MDHHS Field Office notification of Medicaid eligibility or the start date of MI Choice services.
- Waiver "Pending" status should not remain on closed cases. Once a case is closed and the MDHHS Field Office has made a Medicaid determination, the participant is either waiver eligible or not. The eligibility is no longer "Pending". Waiver agencies must have

policies and procedures in place for periodically reviewing all participants with waiver "Pending" status and making adjustments to that status as indicated. Waiver "Pending" is only used for participants whose eligibility status has not yet been determined.

3.9 RE-ENROLLMENT

A re-enrollment occurs when a previous MI Choice participant seeks enrollment in the MI Choice program again. This happens every time the participant's status changes from Waiver/Yes to a non-waiver program, Waiver/Ineligible, Waiver/No, Waiver Financially Ineligible, or Closed and then back to Waiver/Yes.

- The waiver agency must either adopt an existing LOCD or conduct the LOCD according to the requirements set forth in the Nursing Facility Level of Care Determination chapter of this Manual for each re-enrollment, regardless of the reason for the original discharge or program termination.
- The participant must meet all eligibility requirements for the MI Choice program.
- A reassessment may be required before the waiver agency can re-enroll the participant. A reassessment is required if:
  - The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
  - The participant experienced a change in status. A change in status includes, but is not limited to, a medical event (such as a heart attack, stroke, broken bone, or organ transplant) that changed the participant's functional ability, a change in the availability of the participant's informal supports, a noticeable change in the participant's cognitive ability, or a change in the participant's financial situation.
  - The participant has been ineligible for or otherwise out of the MI Choice program for more than one month but remains an open participant with the waiver agency.
- Supports Coordinators (SCs) may perform assessments for a re-enrollment alone or using a team of a registered nurse (RN) and social worker (SW). However, MDHHS requires an RN/SW team in the following situations:
  - The waiver agency completely closed the participant to all agency services, regardless of the length of time between closing and re-enrolling the participant.
  - The participant experienced a change in status related to a decline in the participant's functional ability, informal support availability, or cognitive ability.
  - The participant has been ineligible for or otherwise out of the MI Choice program for at least 90 days.
  - In emergency situations (i.e., when a re-enrollment is to occur within the next three days) when the waiver agency cannot schedule a team reassessment, one SC may start the reassessment process to ensure the participant meets MI Choice eligibility requirements and to develop a temporary PCSP. A SC of the other discipline shall complete the in-person reassessment within seven days of the time the reassessment process began.

3.10 Case Closure

Closed cases are those that SCs determine no longer require intervention. SCs must document this status change in the case records. SCs designate closed case status for the following reasons:

- Death. The SCs shall close the waiver case upon the death of the participant. The last date of waiver enrollment cannot exceed the date of death.
- Moved, Transferred
- Moved, Not Transferred
- Not Eligible
- Nursing Facility Placement
- Refused Service
- ICF/IID Placement
- Transferred to Another Waiver Agency
- Transferred to Another Agency
- Moved to Case Management with other programs
- Hearing
- For Cause
- Administrative
- Other

SCs must document a reason for closure of a case in the participant case record. The waiver agency must notify the participant or proxy in writing of the decision to close the waiver case 10 days before closure, unless an exception to the provision of advanced notice for an adverse benefit determination applies.

SECTION 4 – SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to authorize all approved waiver services that a participant needs to live successfully in the community that are:

- indicated by the current assessment;
- detailed in the person-centered service plan (PCSP); and
- authorized in accordance with the provisions of the approved waiver.

Services must not be authorized unless they are defined in the PCSP and must not precede the establishment of a PCSP. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS, waiver agencies, and direct service providers must not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Services paid for with MI Choice funds must not duplicate nor replace services available through the State Plan. Where applicable, the participant must use State Plan, Medicare, or other available payers first. MI Choice is the funding source of last resort. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

Providers must have previous relevant experience or training for the tasks specified and authorized in the PCSP. The waiver agency must deem the chosen provider capable of performing the required tasks.

For services involving transportation paid for with MI Choice funds, the Secretary of State must appropriately license all drivers and vehicles, and all vehicles must be appropriately insured as required by law.

Healthcare Common Procedure Coding System (HCPCS) codes for each service can be found in the Directory Appendix of the Medicaid Provider Manual.

4.1 COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections.

4.1.A. Adult Day Health

Definition	Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the PCSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., three meals per day). Physical, occupational and speech therapies may be furnished as component parts of this service. All Adult Day Health providers must comply with the federal Home and Community Based Settings Final Rule. Requirements are described in the Home and Community Based Services chapter of this Manual.

Requirements	Each program must keep all participant files confidential in controlled access files. Each program must use a standard release of information form that is time limited and specific as to the released information. Each program must maintain comprehensive and complete files that include, at a minimum:
	
	▪ Details of the participant's referral to the adult day health program,
	▪ Intake records,
	▪ A copy of the MI Choice assessment (and reassessments),
	▪ A copy of the MI Choice PCSP,
	▪ Listing of participant contacts and attendance,
	▪ Progress notes in response to observations (at least monthly),
	▪ Notation of all medications taken on premises, including:
	  ➢ The medication;
	  ➢ The dosage;
	  ➢ The date and time of administration;
	  ➢ The initials of the staff person assisting with administration; and
	  ➢ Comments
	▪ Notation of basic and optional services provided to the participant,
	▪ Notation of all releases of information about the participant, and
	▪ A signed release of information form.
	
	Each program must provide directly, or arrange for, the provision of the following services. If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities must be in place. For MI Choice participants, the waiver agency must provide supports coordination.
	
	▪ Transportation.
	▪ Personal Care.
	▪ Nutrition: One hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home-delivered meals service standard. Participants attending from 8-14 hours per day must receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where

	feasible and appropriate. Such modifications must take into consideration participant choice, health, religious and ethnic diet preferences. ▪ Recreation: Consisting of planned activities suited to the needs of the participant and designed to encourage physical exercise, maintain or restore abilities and skill, prevent deterioration, and stimulate social interaction. Each program may provide directly, or arrange for the provision of, the following optional services. If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities must be in place. ▪ Rehabilitative: Physical, occupational, speech, and hearing therapies provided by licensed professionals under order from a physician. ▪ Medical Support: Laboratory, x-ray, or pharmaceutical services provided by licensed professionals under order from a physician. ▪ Services within the scope of the Nursing Practice Act (PA 368 of 1978). ▪ Dental: Under the direction of a dentist. ▪ Podiatric: Provided or arranged for under the direction of a physician. ▪ Ophthalmologic: Provided or arranged for under the direction of an ophthalmologist. ▪ Health counseling. ▪ Shopping assistance/escort. Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health center separately. If the provider operates its own vehicles for transporting participants to and from the program site, the provider must meet the following transportation minimum standards: ▪ All paid drivers must be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider must make such assistance available unless expressly prohibited by either a labor contract or an insurance policy. ▪ All paid drivers must be trained to cope with medical emergencies unless expressly prohibited by a labor contract. ▪ Each program must operate in compliance with PA 1 of 1985 regarding seat belt usage. A referral from a waiver agency for a MI Choice participant must replace any screening or assessment activities performed for other program participants. The adult day health service provider must accept copies of the MI Choice assessment and PCSP to eliminate duplicate assessment and service planning activities. Each program must establish written procedures (reviewed and approved by a consulting pharmacist, physician, or registered nurse) that govern the assistance

	given by staff to participants taking their own medications while participating in the program. The policies and procedures must minimally address: ▪ Written consent from the participant or participant's representative to assist in taking medications. ▪ Verification of the participant's medication regimen, including the prescriptions and dosages. ▪ The training and authority of staff to assist participants with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place. ▪ Procedures for medication set-up. ▪ Secure storage of medications belonging to, and brought in by, participants. ▪ Disposal of unused medications for participants that no longer participate in the program. ▪ Instructions for entering medication information in participant files, including times and frequency of assistance. Each provider must employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider must continually provide support staff at a ratio of no less than one staff person for every 10 participants. The provider may only provide health support services under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, the provider must maintain a written agreement that clearly specifies the terms of the arrangement between the provider and the other individual or organization. Staff must have basic first-aid training as well as other training as described in the Providers Section of this chapter. Each provider must have first-aid supplies available at the program site. The provider must make a staff person knowledgeable in first-aid procedures, including Cardiopulmonary Resuscitation (CPR), present at all times when participants are at the program site. Each provider must post procedures to follow in emergencies (fire, severe weather, etc.) in each room of the program site. Providers must conduct practice drills of emergency procedures once every six months. The program must maintain a record of all practice drills. The provider must maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each day care center must have the following furnishings: ▪ At least one straight back or sturdy folding chair for each participant and staff person. ▪ Lounge chairs or day beds as needed for naps and rest periods. ▪ Storage space for participants' personal belongings. ▪ Tables for both ambulatory and non-ambulatory participants. ▪ A telephone accessible to all participants. ▪ Special equipment as needed to assist persons with disabilities.

	Each day care center must document that it is in compliance with: ▪ Barrier-free design specifications of Michigan and local building codes. ▪ Fire safety standards. ▪ Applicable Michigan and local public health codes.
Limitations	Participants cannot receive Community Living Supports (CLS) while at the Adult Day Health center. Payment for Adult Day Health services includes all services provided while at the center. CLS may be used in conjunction with Adult Day Health services but cannot be provided at the exact same time. Participants must require regular supervision to live in their own homes or the homes of a relative. Participants with caregivers must require a substitute caregiver while their regular caregiver is at work, in need of respite, or otherwise unavailable. Participants must have difficulty performing activities of daily living (ADL) without assistance. Participants must be capable of leaving their residence with assistance to receive service. Participants are in need of intervention in the form of enrichment and opportunities for social activities to prevent or postpone deterioration that would likely lead to institutionalization. HCPCS codes S5101 and S5102 are limited to one unit per day.

4.1.B. Chore Services

Definition	Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, securing loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.
Requirements	Waiver funds used to pay for chore services may include materials and disposable supplies used to complete the chore tasks. The waiver agency may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver participants. Only properly licensed suppliers may provide pest control services.

4.1.C. Community Health Worker

Definition	The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists participants with obtaining access to community resources. The CHW may also perform the duties of a supports broker, providing assistance throughout the planning and implementation of the PCSP, assist the participant in making informed decisions about what works best for the participant, and assists with access to housing and employment. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring and managing workers

	as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist participants with completion of applications for programs for which they may be eligible. The CHW must work in close collaboration with the participant's Supports Coordinator as the Supports Coordinator has ultimate responsibility for the participant's case.
Requirements	The CHW service is not limited to nursing facility or hospital transitions. The service is available to any participant who may benefit from additional hands-on support to obtain assistance in the community. The CHW visits the participant at home within three days of hospital or facility discharge to review the discharge paperwork and any other documentation, reviews any medications received or orders that need to be filled, reminds the participant of the importance of filling the medications, and talks with the participant about the importance of following up with the physician. If needed, the CHW may make calls for medication to be filled, or to arrange for the follow-up appointment with the physician. The CHW also trains the participant about anything to be aware of and what to do if their condition worsens. The CHW does another follow-up visit within 30 days to determine whether the participant followed up with the physician, took the prescribed medications, and followed any other discharge recommendations. The CHW must thoroughly document what was discussed and discovered during the contacts with the participant so the Supports Coordinator is aware of what occurred. If there are medication discrepancies, the CHW will follow up with the RN Supports Coordinator to get those issues addressed. The CHW may also visit the individual in the nursing facility or hospital to ensure the staff knows who to contact to coordinate the discharge home. The CHW ensures the nursing facility or hospital staff has the contact of the Supports Coordinator with whom the discharge should be coordinated. If the Supports Coordinator wishes and the participant agrees, the CHW will be in contact with the nursing facility if a participant goes from a hospital to a nursing facility for temporary rehab before returning to the Waiver. The CHW may assist with coordinating any supplies, services, etc. the participant requires at home after rehabilitation. Providers for the CHW service may be unlicensed but must be trained in the duties of the job.

4.1.D. Community Living Supports

Definition	Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in community settings. CLS includes assistance to enable participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision.

Requirements	CLS includes: ▪ Assisting, reminding, cueing, observing, guiding and/or training in: ➢ Activities of Daily Living (ADL) such as bathing, eating, dressing, personal hygiene, toileting, transferring, etc. ***** ➢ Laundry and other household activities ➢ Non-medical care (not requiring nurse or physician intervention) * ➢ Meal preparation (does not include the cost of the meals themselves) ➢ Money management ➢ Shopping for food and other necessities of daily living ➢ Social participation, relationship maintenance, and building community connections to reduce personal isolation ➢ Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work * ➢ Transportation from the participant's residence to medical appointments, community activities, among community activities, and from the community activities back to the participant's residence ➢ Routine, seasonal, and heavy household care and maintenance ➢ Attendance at medical appointments ➢ Participation in regular community activities incidental to meeting the individual's community living preferences ▪ Reminding, cueing, observing or monitoring of medication administration.***** ▪ Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual's PCSP.***** ▪ Staff assistance with preserving the health and safety of the participant in order that they may reside and be supported in the most integrated independent community setting.***** ▪ Observing and reporting any change in the participant's condition and the home environment to the supports coordinator.***** As applicable to the tasks being performed, the direct service provider furnishing CLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable. When the CLS services provided to the participant include tasks identified with an asterisk (*****) above, the direct service providers furnishing CLS must also: ▪ Be supervised by a RN licensed to practice nursing in Michigan. At the State's discretion, other qualified individuals may supervise CLS providers. For licensed residential settings, persons employed as facility owners or managers qualify to provide this supervision. The direct care worker's supervisor must be available to the worker at all times the worker is furnishing CLS services.

	▪ Develop in-service training plans and ensure all workers providing CLS services are confident and competent in the following areas before delivering CLS services to MI Choice participants, as applicable to the needs of that participant: safety, body mechanics, and food preparation including safe and sanitary food-handling procedures. ▪ Provide an RN to individually train and supervise CLS workers who perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care for each participant who requires such care. The supervising RN must ensure each worker's confidence and competence in the performance of each task required. ▪ MDHHS strongly recommends each worker delivering CLS services complete a certified nursing assistant (CNA) training course, first aid, and CPR training. When the CLS services provided to the participant include transportation, the following standards apply: ▪ Waiver agencies may not use waiver funds to purchase or lease vehicles for providing transportation services to waiver participants. ▪ All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. ▪ The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies unless expressly prohibited by a labor contract or insurance policy. ▪ Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage. ▪ When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant. Individuals providing CLS must be at least 18 years old, and able to communicate effectively both orally and in writing and follow instructions. Members of a participant's family may provide CLS to the participant. However, waiver agencies must not directly authorize MI Choice funds to pay for services furnished to a participant by that person's spouse. Family members who provide CLS must meet the same standards as providers who are not related to the participant. The waiver agency or provider agency must train each worker to perform properly each task required for each participant the worker serves before delivering the service to that participant. The supervisor must ensure that each worker competently and confidently performs every task assigned for each participant served.

	Each direct service provider who chooses to allow staff to assist participants with self-medication must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: ▪ The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications. CLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158: ▪ A provider must only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable. ▪ A provider must ensure that medication use conforms to federal standards and the standards of the medical community. ▪ A provider must not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment. ▪ A provider must review the administration of a psychotropic medication periodically as set forth in the participant's PCSP and based upon the participant's clinical status. ▪ If a participant cannot administer their own medication, a provider must ensure that medication is administered by or under the supervision of personnel who are qualified and trained. ▪ A provider must record the administration of all medication in participant's clinical record. ▪ A provider must ensure that staff report medication errors and adverse drug reactions to the participant's physician immediately and properly, and record the incident in the participant's clinical record. CLS provided in a residential setting like assisted living, Adult Foster Care, or Homes for the Aged, includes only those services and supports that are in addition to, and must not replace, usual and customary supports and services furnished to residents in the licensed setting. CLS does not include the costs associated with room and board. Documentation in the participant's record must clearly identify the participant's need for additional supports and services not covered by licensure. The PCSP must clearly identify the portion of the participant's supports and services covered by CLS. Homemaking tasks incidental to the provision of assistance with ADL may also be included in CLS but must not replace usual and customary homemaking tasks required by licensure. When CLS services are provided to the participant under a self-determination arrangement, the individual furnishing CLS must also be trained in cardiopulmonary

	resuscitation. This training may be waived when the provider is furnishing services to a participant who has a "Do Not Resuscitate" order. These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.
Limitations	CLS does not include the costs associated with room and board. When transportation incidental to the provision of CLS is included, the waiver agency must not also authorize transportation as a separate waiver service for the participant. CLS excludes nursing and skilled therapy services. The phrase "These services are provided only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision" included in the definition of this service shall be interpreted as follows: ▪ All informal supports must agree to provide the uncompensated (informal) services and supports to the participant as specified in the PCSP. Specifically, the record must show the following: ➢ All persons providing informal services and supports included on the PCSP are aware of and capable of performing the tasks assigned to them for the benefit of the participant as included in the person-centered service plan. ➢ All informal supports agree to any financial liability related to the informal services and supports assigned to them on the person-centered service plan. This includes uncompensated or voluntary transportation of the participant. ➢ Supports coordinators or other waiver agency staff did not arbitrarily assign the completion of services and supports that could otherwise be included as CLS to informal supporters. Rather, both the participant (or their responsible party) and the informal support agree in writing (by their signature on the person-centered service plan) to the provision of the identified services and supports as discussed during a person-centered planning meeting. Relatives, caregivers, landlords, community or volunteer agencies, or other third-party payers have been contacted on behalf of the participant and agree to provide services and supports to the participant because they are both capable of and responsible for the provision of the identified services and supports. This agreement is noted by an authorized signature on the person-centered service plan from a representative of the entity identified as responsible for the services and supports.

4.1.E. COMMUNITY TRANSPORTATION

Definition	Community transportation (CT) service includes both non-emergency medical transportation and non-medical transportation. Community transportation services are offered to enable waiver participants to access waiver services and other community services, activities, and resources as specified in

	the person-centered service plan. The community transportation service may also include expenses related to transportation and other travel expenses determined necessary to secure medical examinations, appointments, documentation, or treatment for participants.
Requirements	Waiver agencies will ensure MI Choice participants have access to community transportation as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize community transportation. Community transportation services include, but are not limited to, transportation to obtain the following medical services: ▪ Chronic and ongoing treatment; ▪ Prescriptions; ▪ Medical supplies and devices; ▪ One-time, occasional and ongoing visits for medical care; and ▪ Services received at a Veterans' Affairs hospital. Travel expenses related to the provision of community transportation include: ▪ The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation; ▪ Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant; ▪ The cost of meals and lodging en route to and from medical care, and while receiving medical care; ▪ The cost of an attendant to accompany the MI Choice participant, if necessary; ▪ The cost of the attendant's transportation, meals, and lodging when transporting to or from medical care; and ▪ The attendant's salary if the attendant is not a volunteer or a member of the MI Choice participant's family who is not already a paid caregiver. Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing community transportation services through the MI Choice program. When authorizing CT, waiver agencies are to authorize the least expensive available means suitable to the participant's needs. Waiver agencies may only authorize CT to provide transportation assistance to the participant. The participant must travel away from home to other locations within the community. CT does not include reimbursement for caregivers of the participant to run errands or otherwise travel on behalf of the participant. Each provider must operate in compliance with PA 1 of 1985 regarding seat belt usage unless the provider is a volunteer driver only seeking mileage reimbursement. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing CT through the MI Choice program.

	Waiver agencies must use the SC modifier when billing for ancillary items that are only available for specific medically-related travel. This includes meals (A0190, A0210), lodging (A0180, A0200), and waiting time for air ambulances and non-emergency vehicles (T2007). Waiver agencies may utilize a process to prior authorize requests for the following: ▪ All outstate travel that is non-borderland for medical treatment. ▪ Overnight stays if within 50 miles one-way from the participant's home for medical treatment. ▪ Overnight stays beyond five nights, including meals and lodging, when traveling for medical treatment. ▪ An attendant in addition to the driver of a wheelchair lift/medivan vehicle. ▪ Mileage and meal expenses for daily long-distance trips for medical treatment.
Limitations	When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or CLS), there must be mechanisms to prevent the duplicative billing of CT. Waiver agencies must not authorize MI Choice CT services to reimburse caregivers (paid or informal) to run errands for participants when the participant does not accompany the driver in the vehicle. The purpose of the CT service is to enable MI Choice participants to gain access to medical services and community activities/outings. Reimbursement for CT **DOES NOT** include the following: ▪ Waiting time, unless for an air ambulance or non-emergency vehicle. ➢ Waiting times may be covered if built into the transportation reimbursement rate. Waiting times are also covered if the participant cannot wait for the transportation vehicle after outings due to medical conditions (i.e., cannot stay in wheelchair for long periods of time due to swelling or pain, etc.). ▪ Transportation for medical services that have already been provided. ▪ Transportation costs to meet a participant's personal choice of provider for routine medical care outside the community when comparable care is available locally. Participants are encouraged to obtain medical care in their own community unless referred elsewhere by their local health care professional. ▪ Reimbursement for meals or lodging when the purpose of travel is not related to the receipt of Medicaid-covered medical services. Meals and lodging are only reimbursed when the participant and attendant are traveling to seek Medicaid-covered medical services. All paid drivers for transportation providers supported entirely or in part by MI Choice funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider must offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider must train all paid drivers for transportation programs supported entirely or in part by MI Choice funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

4.1.F. Counseling

Definition	Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.
Requirements	Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs. Providers receiving waiver funds for counseling services must provide the following service components, at a minimum: ▪ Psychosocial evaluation to determine appropriateness of counseling options. ▪ Treatment plan that states goals and objectives, and projects the frequency and duration of service. ▪ Individual, family, and/or group counseling sessions. ▪ Home visits and on-site counseling. ▪ Case conferencing with a waiver supports coordinator at least once every six weeks with participant's release. Persons providing counseling services must: ▪ Have a master's degree or higher in social work, psychology, psychiatric nursing, or counseling, or ▪ Have a bachelor's degree in one of the above areas and be under the supervision of a mental health professional with a master's degree or higher, AND ▪ Be licensed in the State of Michigan.

4.1.G. Environmental Accessibility Adaptations

Definition	Environmental Accessibility Adaptations (EAA) include physical adaptations to the home required by the participant's person-centered service plan that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.
Requirements	Adaptations may include: ▪ Installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Modification of kitchen facilities;

	▪ Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and ▪ Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers. Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service. The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need(s). An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing. The participant must agree to the reasonable alternative prior to starting the modifications. Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home. The waiver agency must ensure there is a signed contract or bid proposal with the licensed builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and the licensed builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. The waiver agency must document approval of all EAA in the participant's record. This documentation must minimally include dates, tasks performed, materials used, and cost. All services must be provided in accordance with applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes. The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values. Under the EAA service, waiver agencies may use MI Choice funds to purchase materials and labor used to complete the modifications to prevent or remedy a sub-standard condition or safety hazard. The direct service provider must provide equipment or tools needed to perform modifications or adaptations unless another source can provide the tools or equipment at a lower cost or free of charge and the provider agrees to use such equipment or tools. The waiver agency may purchase supplies for the modification or adaptation, such as grab bars, lumber, or plumbing supplies, and provide them to the direct service provider at their discretion. The participant, with the direct assistance of the waiver agency's supports coordinator when necessary, must make a reasonable effort to access all available funding sources such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants. Before approving MI Choice payment for each modification or adaptation, each waiver agency must determine whether a participant is eligible to receive services through a program supported by other funding sources. The participant's case record must include

	evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. Adaptations may be made to rental properties when the lease or rental agreement does not indicate that the landowner is responsible for such adaptations and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves. Providers of EAA must be licensed in the State of Michigan.
Limitations	Excluded are those adaptations or improvements to the home that: ▪ Are of general utility. ▪ Are considered to be standard housing obligations of the participant or homeowner. ▪ Are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to: ▪ Carpeting ▪ Roof repair ▪ Sidewalks and driveways ▪ Heating ▪ Central air conditioning (except under exceptions noted in the service definition) ▪ Garages and raised garage doors ▪ Storage and organizers ▪ Hot tubs, whirlpool tubs, and swimming pools ▪ Landscaping ▪ General home repairs MI Choice does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations shall exclude costs for improvements exclusively required to meet applicable state or local building codes. The existing structure must have the capability to accept and support the proposed changes.

4.1.H. Fiscal Intermediary

Definition	Fiscal Intermediary (FI) services assist participants who choose the self-determination option in acquiring and maintaining services defined in the participant's person-centered service plan, controlling a participant's budget, and choosing staff authorized by the waiver agency. The Fiscal Intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's person-centered service plan. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures, and ensuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history reviews, and assisting the participant to understand billing and documentation requirements.
Requirements	Each FI must be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering. Each FI must demonstrate the ability to manage budgets and perform all functions of the FI, including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations. Each FI must demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Each FI will provide four basic areas of performance: ▪ Function as the employer agency for participants directly employing workers to ensure compliance with payroll tax and insurance requirements; ▪ Ensure compliance with requirements related to management of public funds, the direct employment of workers by participants, and contracting for other authorized goods and services; ▪ Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each participant and waiver agency; and ▪ Offer supportive services to enable participants to self-determine and direct the services and supports they need. The waiver agency and FI must abide by the principles set forth in the Self-Determination Technical Advisory "Choice Voucher System" available in the Directory Appendix. Participants choosing self-determination and utilizing the Agency with Choice option do not have to utilize a fiscal intermediary. Participants using the Agency with Choice option may choose to have the agency perform the four basic areas of performance outlined above.

Limitations	FI services are only available to those participants choosing the self-determination option for service delivery. Providers of other covered services to the participant, family, or guardians of the participant may not provide FI services to the participant.

4.1.I. Goods and Services

Definition	Goods and Services are services, equipment or supplies not otherwise provided through either the MI Choice Waiver or the State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements.
Requirements	Each item or service specified in the PCSP must meet the following requirements: ▪ Decrease the need for other Medicaid services. ▪ Promote inclusion in the community. ▪ Increase the participant's safety in the home environment. ▪ The participant does not have the funds to purchase them or they are not available through another source. Goods and Services are only approved by CMS for participants choosing the self-determination option. Self-directed Goods and Services are purchased from the participant-directed budget. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.
Limitations	This service is only available to those participants choosing self-determination. This service excludes experimental or prohibited treatments.

4.1.J. Home Delivered Meals

Definition	Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances must be made in HDMs for specialized or therapeutic diets as indicated in the person-centered service plan. A HDM cannot constitute a full nutritional regimen.
Requirements	Each waiver agency must have written eligibility criteria for persons receiving home delivered or congregate meals authorized through the waiver program which include, at a minimum: ▪ The participant must be unable to consistently obtain food or prepare complete meals. ▪ The participant does not have an adult living at the same residence or in the vicinity who is able and willing to prepare all meals. ▪ The participant does not have a paid caregiver who is able and willing to prepare meals for the participant.

	▪ The provider can appropriately meet the participant's special dietary needs, and the meals available will not jeopardize the participant's health. ▪ The participant must be able to feed themself. ▪ The participant must agree to be home when meals are delivered, or contact the program when an absence is unavoidable. Federal regulations prohibit the MI Choice program from providing three meals per day to waiver participants. Providers must vary the level of meal service for an individual in response to varying availability of help from allies and formal caregivers, and changes in the participant's status or condition. When MI Choice provides home delivered meals less than seven days per week, the waiver agency must identify and document in the case record the usual source of all meals for the participant that are not provided by the program. HDM providers and waiver agencies must follow the home delivered meals guidelines provided in the Directory Appendix. When developing menus, MDHHS encourages every attempt to include key nutrients and to follow other dietary recommendations that relate to lessening chronic disease and improving the health of MI Choice participants. Diabetes, hypertension, and obesity are three prevalent chronic conditions among all adults in Michigan. Providers should pay special attention to nutritional factors that can help prevent and manage these and other chronic conditions. Providers must use person-centered planning principles when doing menu planning. Examples of person-centered menu planning include offering rather than serving food and providing choices of food as often as possible. Key recommendations from the United States Department of Agriculture (USDA) Dietary Guidelines for Americans (DGA) should be considered when planning meals and minimally contain 33 1/3 percent of the current DRI as established by the Food and Nutrition Board of the National Academy of Science, National Research Council. Each provider must have written policies and procedures that integrate person-centered planning into the home delivered and congregate meals program. This includes allowing participants to attend congregate meals sites when they have transportation or help to the site and providing diet modifications, as requested by the participant when the provider is able to do so while following established nutritional guidelines. Each home delivered or congregate meals provider must have the capacity to provide three meals per day, which together meet the dietary reference intake (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences. Each provider must have meals available at least five days per week. The provider may offer liquid meals to participants when ordered by a physician. The regional dietitian must approve all liquid meals products used by the provider. The provider or supports coordinator must provide instruction to the participant, the participant's caregiver, and participant's family in the proper care and handling of liquid meals. The waiver agency and provider must meet the following requirements when liquid meals are the sole source of nutrition: ▪ Diet orders must include participant weight and specify the required nutritional content of the liquid meals. ▪ The supports coordinator must ensure the participant's physician renews the diet orders every three months, and

	▪ The MI Choice RN supports coordinator and participant must develop the PCSP for participant receiving liquid meals in consultation with the participant's physician. The provider may supply liquid nutritional supplements ordered by a supports coordinator where feasible and appropriate. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician renews the order for liquid nutritional supplements every six months. However, liquid nutritional supplements are classified as a specialized medical supply for purposes of the MI Choice program and must be billed accordingly. The supports coordinator or provider must verify and maintain records that indicate each participant can provide safe conditions for the storage, thawing, and reheating of frozen foods. Frozen foods should be kept frozen at 0 degrees Fahrenheit thawing for consumption. Unless otherwise preferred by the participant, providers must not furnish more than a two-week supply of frozen meals to a participant during one home delivery visit. Each provider must develop and have available written plans for continuing services in emergencies such as short-term natural disasters (e.g., snow and/or ice storms), loss of power, physical plant malfunctions, etc. The provider must train staff and volunteers on procedures to follow in the event of severe weather or natural disasters and the county emergency plan. The emergency plan shall address, but not be limited to: ▪ Uninterrupted delivery of meals to HDM participants, including, but not limited to use of families and friends, volunteers, shelf-stable meals and informal support systems; ▪ Provision of at least two, and preferably more, shelf-stable meals and instructions on how to use for participants. Every effort should be made to assure that the emergency shelf-stable meals meet the nutrition guidelines. If it is not possible, shelf-stable meals will not be required to adhere to the guidelines. ▪ MI Choice participants may receive two emergency meals. ▪ Back-up plan for food preparation if usual kitchen facility is unavailable; ▪ Agreements in place with volunteer agencies, individual volunteers, hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation, and delivery; ▪ Communications system to alert congregate and home-delivered meals participants of changes in meal site/delivery; ▪ The plan shall cover all the sites and participants for each provider, including sub-contractors of the provider. A record of the menu actually served each day shall be maintained for each fiscal year's operation. Monthly nutrition education sessions must be offered at each meal site and as appropriate to home-delivered meal participants. Emphasis should focus on giving the participant the information and tools to make food choices in relation to health and wellness, and to any chronic diseases they may have, including making choices at the meal site, at home, and when they eat out.

	Topics shall include, but not be limited to, food, nutrition, and wellness issues. Nutrition education materials must come from reputable sources. Questions pertaining to appropriateness of materials and presenters are to be directed to the staff dietitian, regional dietitian or Dietetic Technician, Registered (DTR). Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited English proficiency. At least once per year, the following topics must be covered: ▪ How food choices affect chronic illnesses ▪ Food safety at home and when dining out ▪ Food choices at home ▪ Emergency preparedness- what to have on hand Each provider must operate according to the Michigan Food Code and must have a copy of the most recent version of the Code available for reference. Complaints from participants should be referred to the provider that hosts the site or manages the HDMs. Each provider shall have a written procedure for handling complaints. The provider and waiver agency must develop a plan for what type of complaints need to be referred to the waiver agency. Home Visit Safety. Assessors, HDM drivers, delivery people and other staff are not expected to be placed in situations that they feel unsafe or threatened. Providers must work with their waiver agency to create a "Home Visit Safety Policy" that addresses verbal and physical threats made to the assessor(s), drivers or other program persons, by participants, family members, pets (animals) or others in the home during the assessment. This policy should include, but is not limited to: ▪ Definition of a verbal or physical threat; ▪ How a report should be made/who investigates the report; ▪ What actions should be taken by the assessor or driver if they are threatened; ▪ What warnings should be given to the participant; ▪ What actions should be taken for repeated behaviors; ▪ What information gets recorded in the chart; and ▪ Situations requiring multiple staff/volunteers.
Limitations	The meals authorized under this service must not constitute a full nutritional regimen. Providers must not solicit donations from waiver participants. Providers must not use waiver funds to purchase dietary supplements such as vitamins and minerals. When the participant has informal supports or paid caregivers available during meal times, the case record must clearly document the need for a home delivered meal.

4.1.K. Nursing Services

Definition	Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home. These services are provided by a

	registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the State Plan or third party payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant, such as hospitalizations and nursing facility admissions.
Requirements	When the participant's condition is unstable, could easily deteriorate, or significantly changes, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health professional to prevent additional decline, illness, or injury to the participant. The supports coordinator must communicate with both the nurse providing this service and the participant's health professional to ensure the nursing needs of the participant are being addressed. Participants must meet at least one of the following criteria to qualify for this service: ▪ Be at high risk of developing skin ulcers or have a history of resolved skin ulcers that could easily redevelop. ▪ Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen. ▪ Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management. ▪ Require professional assessment of the participant's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function, or identify the need for modifications to the medication regimen. ▪ Require professional evaluation of the participant's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary. ▪ Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes. ▪ Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the participant's physician or other appropriate health professional. In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services: ▪ Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)). ▪ Setting up medications according to physician orders. ▪ Monitoring participant's adherence to their medication regimen. ▪ Applying dressings that require prescribed medications and aseptic techniques. ▪ Providing refresher training to the participant or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

Limitations	This service is limited to no more than two hours per visit unless a reason for a longer visit is clearly documented in the participant's record (such as requiring three hours to complete a complicated dressing change). Participants receiving Private Duty Nursing/Respiratory Care services are not eligible to receive MI Choice Nursing Services. All providers furnishing this service must be licensed as either a Registered Nurse or a Licensed Practical Nurse in the State of Michigan.

4.1.L. Personal Emergency Response System

Definition	A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided.
Requirements	The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The participant must reside in an area where the cellular or mobile coverage is reliable. When the participant uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The response center must maintain the monitoring capacity to respond to all incoming emergency signals 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put in a first call, first serve basis. The provider will furnish each responder with written instructions and provide training, as appropriate. The provider will verify the responder and contact names for each participant on a semi-annual basis to ensure current and continued participation. The provider will ensure at least monthly testing of each PERS unit to ensure continued functioning. The provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and caregivers in the use of the devices, as well as to provide performance checks. The provider will maintain individual client records that include the following: ▪ Service order, ▪ Record of service delivery, including documentation of delivery and installation of equipment, participant/caregiver orientation, and monthly testing, ▪ List of emergency responders for each participant, and ▪ A case log documenting participant and responder contacts. The Federal Communication Commission must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

Limitations	PERS does not cover monthly telephone charges associated with phone service. PERS is limited to persons who either live alone or who are left alone for significant periods on a routine basis and who could not summon help in an emergency without this device. Waiver agencies may authorize PERS units for persons who do not live alone if both the participant and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. The supports coordinator must clearly document in the case record the reason for provision of a PERS. Waiver agencies may provide a purchased unit like a PERS device. This type of unit does not require an installation or monthly fee but is a one-time cost. These units are covered under the Specialized Medical Equipment and Supplies service. Participants should not have both a purchased and a rented unit.

4.1.M. PRIVATE DUTY NURSING/RESPIRATORY CARE [CHANGE MADE 7/1/2025]

Definition	Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of skilled assessment, treatment, and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the participant's person-centered service plan. RC may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. The participant's PCSP must provide reasonable assurance of participant safety. This includes a strategy for effective backup in the event of an absence of providers. The backup strategy must include informal supports or the participant's capacity to manage their care and summon assistance. PDN/RC for a participant between the ages of 18-21 is covered under the State Plan.
Requirements	Through a person-centered planning process, the waiver agency must determine the length and duration of services provided. The direct service provider must maintain close contact with the authorizing waiver agency to promptly report changes in each participant's condition and/or treatment needs upon observation of such changes. The direct service provider must send case notes to the supports coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the supports coordinator on the condition of the participant. This service may include medication administration as defined under Michigan law. The waiver agency is responsible for assuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN/RC services. However, the waiver agency is responsible for assuring the PDN/RC provider has a copy of these orders and delivers PDN/RC services according to the orders. The waiver agency must maintain a copy of the physician orders in the case record.

Medical Criteria	To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III. **Medical Criteria I** – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means: ▪ Mechanical rate-dependent ventilation (four or more hours per day) or assisted rate-dependent respiration (e.g., some models of bi-level positive airway pressure [Bi-PAP]); or ▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below. **Medical Criteria II** – Frequent episodes of medical instability within the past three to six months requiring skilled assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions of Medical Criteria II: ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder. ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition. ▪ "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

	▪ "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL. ▪ "Substantiated" means documented in the clinical or medical record, including the progress notes. **Medical Criteria III** – The participant requires continuous skilled care on a daily basis during the time when a licensed nurse or respiratory therapist is paid to provide services. Definitions of Medical Criteria III: ▪ "Continuous" means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. ▪ Equipment needs alone do not create the need for skilled services. ▪ "Skilled" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse or respiratory therapist. Skilled care includes, but is not limited to: ➢ Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions. ➢ Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day. ➢ Deep oral (past the tonsils) or tracheostomy suctioning. ➢ Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled intervention). ➢ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility. ➢ Total parenteral nutrition delivered via a central line and care of the central line. ➢ Continuous oxygen administration (eight or more hours per day) in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below. ➢ Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms.

	➢ Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.
Limitations	Participants receiving MI Choice Nursing Services are not eligible to receive PDN/RC services. All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria described above. The participant's physician, physician assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to ensure services are delivered according to that order. Orders should be updated on an annual basis unless the order states otherwise due to ongoing medical need that is unlikely to improve over time. PDN is limited to persons age 21 or older. PDN is a State Plan benefit for persons under the age of 21 who qualify for the service. It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described on the person-centered service plan and approved by MDHHS. PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis. A need for 24/7 PDN/RC cannot be used as a primary reason for denying MI Choice eligibility or enrollment as there are circumstances when 24/7 PDN/RC may be appropriate for MI Choice participants. For all individuals requiring 24/7 PDN/RC, an assessment, person-centered service plan, backup/contingency plan, and order from a medical professional must be submitted to MDHHS for review and decision. **(text added 7/1/2025)** Providers of PDN/RC must be licensed by the State of Michigan.

4.1.N. RESPITE

Definition	Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those unpaid individuals normally providing services and supports for the participant. Respite services may be provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, nursing facility, or a licensed Adult Foster Care (AFC) facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence. Respite can only be provided in the home of another when the participant is using the self-determination option for service delivery. Each out-of-home respite service provider must be either a Medicaid-certified hospital or a licensed group home as defined in Michigan law, which includes AFC homes and Homes for the Aged. Properly licensed nursing facilities may be providers of out-of-home respite services.

Requirements	Each waiver agency must establish and follow written eligibility criteria for in-home respite that includes, at a minimum: ▪ Participants must require continual supervision to live in their own homes or the home of a primary caregiver, or require a substitute caregiver while their primary caregiver needs relief or is otherwise unavailable. ▪ Participants have difficulty performing or are unable to perform ADL without assistance. Respite services include: ▪ Attendant Care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation. ▪ Basic Care (participant may or may not be bed-bound), such as assistance with ADL, a routine exercise regimen, and self-medication. The direct service provider must obtain a copy of appropriate portions of the assessment conducted by the waiver agency before initiating service. The assessment information must include a recommendation made by the assessing RN describing the respite support services the participant needs. Each waiver agency or direct service provider must ensure the skills and training of the respite care worker assigned coincide with the condition and needs of the participant. With the assistance of the participant or participant's caregiver, the waiver agency or direct service provider must determine an emergency notification plan for each participant, pursuant to each visit. Each direct service provider must establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures must be reviewed by a consulting pharmacist, physician, or RN and must include, at a minimum: ▪ The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. ▪ Verification of prescription medications and their dosages. The participant must maintain all medications in their original, labeled containers. ▪ Instructions for entering medication information in participant files. ▪ A clear statement of the participant's and participant's family's responsibility regarding medications taken by the participant and the provision for informing the participant and the participant's family of the provider's procedures and responsibilities regarding assisted self-administration of medications. Each direct service provider must employ a professionally qualified supervisor that is available to staff during their shift while providing respite care. There is a 30-days-per-calendar-year limit on respite services provided outside the home. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Members of a participant's family who are not the participant's regular caregiver may provide respite for the regular caregiver. However, waiver agencies must not authorize MI Choice funds to pay for services furnished to a participant by that

	person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual. The waiver agency must not authorize respite services to relieve a caregiver that receives waiver funds to provide another service to the waiver participant. This requirement may be waived if: ▪ The case record demonstrates the participant has a medical need for services and supports in excess of the authorized amount of MI Choice services (i.e., the participant has a medical need for 50 hours per week of services); and ▪ The case record demonstrates the paid caregiver furnishes unpaid services and supports to the participant (i.e., the caregiver is paid for 30 hours per week, but actually delivers 50 hours per week of services); and ▪ The paid caregiver is requesting respite for the services and supports not usually authorized through the MI Choice program (i.e., for all or part of the 20 hours of medically necessary, but unpaid services the caregiver regularly furnishes).
Limitations	MDHHS does not intend to furnish respite services on a continual basis. Respite services should be utilized for the sole purpose of providing temporary relief to an unpaid caregiver. When a caregiver is unable to furnish unpaid medically necessary services on a regular basis, waiver agencies should work with the participant and caregiver to develop a PCSP that includes other MI Choice services, as appropriate. The costs of room and board are not included. Waiver agencies cannot authorize respite services on a continual daily basis. Waiver agencies may authorize respite services on a daily basis for a short period, such as when informal supports are on vacation. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. The waiver agency must not authorize waiver funds to pay for respite services provided by the participant's usual caregiver.

4.1.O. Specialized Medical Equipment and Supplies

Definition	Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items. This includes durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations. All items must be specified in the PCSP. This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the participant's PCSP. All items must meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and

	maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.
Requirements	Waiver agencies may obtain some items directly from a retail store that offers the item to the public (i.e., Wal-Mart, Meijer, Costco, etc.). When utilizing retail stores, the waiver agency must ensure the item purchased meets the service standards. The waiver agency may choose to open a business account with a retail store for such purchases. The waiver agency must maintain the original receipts and maintain accurate systems of accounting to verify the specific participant who received the purchased item. The waiver agency must document the medical or remedial benefit the equipment or supply provides to the participant in the participant's case record. Where feasible, the waiver agency or direct service provider must seek affirmation of the need for the item provided from the participant's physician. The waiver agency may provide liquid nutritional supplements as a specialized medical supply. The participant's physician or other health care professional must first order liquid nutritional supplements as described in the HDM service standards. When liquid nutrition supplements a participant's diet, the supports coordinator must ensure the physician or other health care professional renews the order for liquid nutritional supplements every six months.
Limitations	The waiver agency may not authorize MI Choice payment for prescription medications not found on the Medicaid prescription drug formulary. If a participant requires a medication not found on the formulary, the waiver agency, participant, or pharmacy must seek prior authorization of payment through the State Plan. Regardless of approval or denial of State Plan prior authorization, MI Choice funds must not pay for the medication. The waiver agency must not authorize MI Choice payment for herbal remedies or other over-the-counter medications for uses not authorized by the Food and Drug Administration (FDA).

4.1.P. SUPPORTS COORDINATION

Definition	Supports coordination is provided to ensure the provision of supports and services required to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the PCSP. The frequency and scope of supports coordination contacts must take into consideration health and welfare needs of the participant. Supports coordination does not include the direct provision of other Medicaid services. Supports coordinators perform all functions described in the Supports Coordination Section of this Chapter.
Requirements	Each supports coordinator must have a valid Michigan license as a Registered Nurse (RN) or Social Worker (SW), and be trained and knowledgeable about the program requirements for MI Choice as well as other available community resources. Functions performed by a supports coordinator include: ▪ Ensure the participant meets the LOCD per MDHHS policy. ▪ Conduct the initial assessment and periodic reassessments.

	▪ Facilitate person-centered planning that is focused on the participant's preferences. Includes family and other allies as determined by the participant, identifies the participant's goals, preferences and needs, provides information about options, and engages the participant in monitoring and evaluating services and supports. ▪ Develop a PCSP, including revisions to the PCSP at the participant's initiation or as changes in the participant's circumstances may warrant. ▪ Communication with the participant is a requirement and must be incorporated into the person-centered service plan. ▪ Make referrals to and coordinate with providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or legal representation.
Limitations	Participant must need and agree to accept at least one additional MI Choice service every 30 days to qualify for the program. Supports coordinators must **not** also provide Transition Navigation under the Transition Services benefit.

4.1.Q. TRAINING

Definition	Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's person-centered service plan. Training is covered for areas such as ADL, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision, or other areas related to self-direction.
Requirements	Direct service providers must possess credentials required by Michigan laws or federal regulations, including: ▪ MCL 333.17801…333.17831 (physical therapist), ▪ MCL 333.18301…333.18311 (occupational therapist), ▪ MCL 333.18501…333.18518 (social worker), and/or ▪ MCL 333.17201…333.17242 (nursing) The waiver agency must identify the training needs in the comprehensive assessment or in a professional evaluation and include them in the PCSP. The waiver agency must provide a description of these needs to the direct service provider. The waiver agency must maintain verification of training provided to self-determined workers in the participant's case record.

4.2 State Plan Services

MI Choice services are designed to address the unique needs and circumstances of program participants. Some waiver services appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of participants, it is expected that a waiver service will be more appropriate for a participant than a similar State Plan service. Under no circumstances shall the participant receive both services. As a Prepaid Ambulatory Health Plan (PAHP), waiver agencies have authority to authorize payment only for MI Choice services for which they receive a capitated payment. Payments to the waiver agency for State Plan services may occur when the waiver agency is a properly enrolled provider for the specified service and conforms to conflict of interest protections.

4.3 Hospice or Palliative Care

MI Choice participants may receive State Plan hospice or palliative care services while participating in MI Choice. Participants must meet all hospice or palliative care eligibility requirements outlined in the Hospice Chapter of this Manual. If the beneficiary is receiving hospice or palliative care and becomes eligible to receive waiver services, the waiver agency contacts the hospice or palliative care provider to establish the first date of service for the waiver services.

State Plan hospice or palliative care services must be used to the fullest extent before similar MI Choice services are authorized. Inappropriate services (e.g., duplicative, non-covered) are subject to MDHHS recovery of the amounts paid for those services from the waiver agency.

A joint plan of service for Hospice or palliative care and MI Choice must be developed and maintained by both the waiver agency and the hospice or palliative care provider. It is important that the waiver agency understand the hospice or palliative care philosophy so the two entities work for a common goal and avoid redundant services. Ongoing communication and coordination must occur between the MI Choice supports coordinator and the hospice or palliative care provider during the time they are serving the participant. Written documentation of this communication and coordination must be kept in the participant's record at each agency.

4.4 Services in Licensed or Provider Controlled Settings

Licensing rules for residential setting providers reflect an attempt to make residing in these settings much like it would be in a home. Providers of licensed residential settings must meet the standards of providing a non-institutional setting licensed by the State of Michigan. For further details on what constitutes a home and community-based setting, refer to 42 CFR §441.530. Both licensed and non-licensed settings in which the provider has control over staffing arrangements and where MI Choice services are furnished must comply with the requirements of the Home and Community Based Services Chapter of this Manual.

4.5 Service Need Levels

Waiver agencies must classify each MI Choice participant into a service need level based upon the participant's immediacy of need for the provision of services and the availability of informal supports. Waiver agencies must establish and utilize written procedures consistent with the service need levels specified below to ensure each participant's needs are met in the event of an emergency. Waiver agencies must make direct service providers aware of the service need levels and the classification of

each participant served by that provider so that the service provider can target services to the highest priority participants in emergencies.

- Immediacy of need for the provision of services
  1. Immediate – the participant cannot be left alone
  2. Urgent – the participant can be left alone for a short time (less than 12 hours)
  3. Routine – the participant can be left alone for a day or two
- Availability of Informal Supports
  1. No informal supports are available for the participant
  2. Informal supports are available for the participant
  3. The participant resides in a supervised residential setting (SRS)

4.5.A. GRID OF SERVICE NEED LEVELS

Immediacy	Informal Supports	Service Need Level	Service Need Level Description
Immediate	None	1A	This means the participant cannot be left alone. If services are not delivered as planned, the backup plan needs to start immediately.
Immediate	Available	1B	This means the participant cannot be left alone. If services are not delivered as planned, family or friends need to be contacted immediately.
Immediate	SRS	1C	This means the participant cannot be left alone. Staff at the place of residence must be available as planned or follow established emergency procedures.
Urgent	None	2A	This means the participant can be left alone for a short time. If services are not delivered as planned, the backup plan needs to start within 12 hours.
Urgent	Available	2B	This means the participant can be left alone for a short time. If services are not delivered as planned, family or friends need to be contacted within 12 hours.
Urgent	SRS	2C	This means the participant can be left alone for a short time. Staff at the place of residence must check on the participant periodically each day. Follow established emergency procedures if no staff is present in the home.
Routine	None	3A	This means the participant can be left alone for a day or two. If services are not delivered as planned, the backup plan needs to start within a couple of days.
Routine	Available	3B	This means the participant can be left alone for a day or two. If services are not delivered as planned, family or friends need to be contacted within a couple of days.
Routine	SRS	N/A	There is not a 3C service need level because participants in supervised residential settings typically require 24-hour supervision and cannot be left alone for long periods.

4.6 Self-Determination

Self-Determination provides MI Choice participants the option to direct and control their own waiver services. Not all MI Choice participants choose to participate in self-determination. For those that do, the participant (or chosen representative[s]) has decision-making authority over staff who provide waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards
- Specifying how services are to be provided and determining staff duties consistent with the service specifications in the approved waiver application and contract attachments
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Participant budget development for participants in self-direction occurs during the person-centered planning (PCP) process and is intended to involve individuals the participant chooses. Planning for the person-centered service plan precedes the development of the participant's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. A participant's budget is not authorized until both the participant and the waiver agency have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized budget, they may reconvene the PCP process. The waiver services of Fiscal Intermediary and Goods and Services are available specifically to self-determination participants to enhance their abilities to more fully exercise control over their services.

Participants choosing the self-determination model for service delivery may also choose to utilize a supports broker to assist with developing the person-centered plan and securing other services (regardless of payer source) that may contribute to the participant's success in home and community-based living and improvements in their quality of life. Supports coordinators should inform all participants of this option and may assist the participant with selecting a supports broker, as needed.

The participant may, at any time, modify or terminate the self-determination option. The most effective method for making changes is the PCP process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may interfere with the success of self-determination. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the person-centered service plan, with the exception of the termination of the self-determination only services, Fiscal Intermediary, and Goods and Services. When the participant terminates self-determination, the waiver agency has an obligation to assume responsibility for ensuring the provision of all other services identified in the person-centered service plan through its provider network.

A waiver agency may terminate self-determination for a participant when problems arise due to the participant's inability to effectively direct services and supports. Prior to terminating self-determination (unless it is not feasible), the waiver agency informs the participant in writing of the issues that have led to the decision to terminate this option. The waiver agency will continue efforts to resolve the issues that led to the termination.

4.6.A. Self-Determined Providers

Participants choosing the self-determination option may directly manage service providers for the following home and community-based MI Choice waiver services: chore, community health worker, community living supports, environmental accessibility adaptations, fiscal intermediary, goods and services, community transportation, private duty nursing/respiratory care, respite services provided inside the participant's home, and respite services provided in the home of another.

4.6.A.1. Supervision of Direct-Care Workers

The MI Choice participant, or designated representative, acts as the employer and provides direct supervision of the chosen workers for self-determined services in the participant's PCSP. The participant, or designated representative, directly recruits, hires, and manages employees.

4.6.A.2. Use of a Fiscal Intermediary

MI Choice participants choosing the self-determination option must use an approved fiscal intermediary agency. The fiscal intermediary agency will help the individual manage and distribute funds contained in the participant's budget. The participant uses the funds in the budget to purchase waiver goods, supports, and services authorized in the participant's PCSP. Refer to the Fiscal Intermediary service standard for more information about this MI Choice service.

4.6.A.3. Reference and Criminal History Screening Checks

Each MI Choice participant, or fiscal intermediary chosen by the participant, must conduct reference checks and a criminal history screening through the Michigan State Police for each paid staff person who will be entering the participant's home. The MI Choice participant or fiscal intermediary must conduct the criminal history screening before authorizing the employee to furnish services in the participant's home. Waiver agencies must also check the Michigan Medicaid sanctioned provider list to determine if the provider is on the list; these providers must be excluded from providing any MI Choice services.

4.6.A.4. Provider Qualifications

Providers of self-determined services must minimally:

- Be 18 years old.
- Be able to communicate effectively both orally and in writing and follow instructions.
- Be trained in universal precautions and blood-borne pathogens. The waiver agency must maintain a copy of the employee's training record in the participant's case file.
- Providers of self-determined services cannot also be the participant's spouse, guardian, legally responsible person, or designated representative.

SECTION 5 – NURSING FACILITY TRANSITIONS

Serving individuals who require long-term supports and services in the least restrictive setting of their choice is a priority of MDHHS. The tenet of rebalancing the spectrum of long-term services and supports in Michigan was given impetus by the 1999 United States Supreme Court decision in Olmstead v. L. C.. Waiver agencies must enroll individuals who are transitioning or discharging from an institutional setting and who qualify for and choose the MI Choice program as slot capacity allows and according to waiting list prioritization. Waiver agencies will work with the Transition Services Transition Navigator or discharge planner to ensure MI Choice enrollment occurs on the date of transition or discharge for the individual to ensure the continuation of services for the individual.

SECTION 6 – SUPPORTS COORDINATION

Supports coordination facilitates access to, and arrangement of, services and supports needed and chosen by MI Choice participants. These are detailed and documented in the person-centered service plan.

Supports coordinators (SCs) use a person-centered approach in working with a participant to determine how their needs will be met. SCs also monitor the quality of services received by the participant and explore other funding options and service opportunities when personal goals exceed the scope of available MI Choice services. For participants choosing the self-determination option for service delivery, the SC assists in the selection, coordination, and management of those services and providers.

Waiver agency staff respects each participant's cultural background.

SCs must receive ongoing training and supervision, as appropriate.

The SCs ensure the participant's rights. This includes the right to participate actively in SC services including the development of the PCSP, the right to use a supports broker, the right to receive or refuse services, the right to choose providers, and the right to participate in a PCP process.

Every MI Choice participant signs a Freedom of Choice form to receive services from MI Choice. CHAMPS will generate this form for each participant once the completed LOCD is entered online. Waiver agencies follow the requirements defined in the Nursing Facility Level of Care Determination Chapter of this Manual. Participants must be informed of the following:

- Services available in MI Choice, PACE, MI Health Link, and nursing facilities. Participants or their legal representative must sign the Freedom of Choice form to indicate their preference for MI Choice. Waiver agencies maintain properly completed, signed, and dated forms in the participant's case record. Waiver agencies must make attempts to get the participant or legal representative to sign the Freedom of Choice form, but a refusal or inability to sign the form is not a reason to deny MI Choice services. If the participant or legal representative refuses to or is unable to sign the form, and the waiver agency has attempted to obtain the signature with documentation of attempts in progress notes, the waiver agency should document this on the Freedom of Choice form. The form should then be maintained in the participant's file. (Refer to additional Freedom of Choice requirements within this chapter.)
- Services available through the State Plan which may meet their needs. Examples include the Home Help program available through the MDHHS Field Office. Persons who qualify for the Home Help program and for whom this program will fully meet their services and support needs do not qualify for the MI Choice program because they do not have the need for a waiver service.

SCs instruct participants regarding how to contact SCs when needed for service and supports changes.

SCs provide all of the following functions: social emotional support, advocacy, assessment, person-centered service planning and development, service access, follow-up and monitoring, and reassessment.

6.1 Social Emotional Support

SCs provide support to participants and their allies to facilitate life adjustments and reinforce the participant's circle of support. SCs also conduct case conferencing as determined necessary and approved by the participant.

6.2 Advocacy

SCs provide support to ensure participants and their families receive benefits and services they need and to which they are entitled. SCs also provide assistance with accessing Medicare, Medicaid, and other third party benefits and services.

6.3 Assessment

The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. The iHC Assessment System, consisting of the iHC and Clinical Assessment Protocols (CAPs), is the basis for the MI Choice assessment. SCs perform a comprehensive evaluation including assessment of the individual's unique preferences; physical, social, and emotional functioning; medication; physical environment; natural supports; and financial status. The SC must fully engage the participant in the interview to the extent of the participant's abilities and tolerance. The initial assessment must be conducted in person.

Specific iHC items identify applicants who could benefit from further evaluation of particular problems and risks for functional decline. These items, called "triggers," link the iHC to a series of problem-oriented CAPs. The CAPs are procedures that guide the SCs through further assessment and individualized service and support planning with participants.

SCs also conduct the LOCD tool to determine if the individual meets functional eligibility.

Qualified SCs perform the initial MI Choice assessment function as a team. Qualified staff includes a RN or SW, both with valid Michigan licenses to practice their profession.

The MI Choice Intake Guidelines, LOCD, and iHC are not interchangeable tools.

6.4 Person Centered Planning and Service Plan Development

SCs and participants plan interventions from both allies and community resources that will meet each participant's identified needs. A written person-centered service plan (PCSP) documents the issues, concerns, conditions, and specific supports and interventions needed. The SC and participant base the PCSP upon participant preferences and needs identified during a PCP assessment process. The PCSP must be completed and approved by the participant within 90 days.

6.4.A. Person-Centered Planning

Person-centered planning (PCP) is a process for planning and supporting a participant receiving services that builds on the participant's desire to engage in lawful activities that promote community life and that honor the participant's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the participant desires or requires. Waiver agencies and direct service providers must utilize a PCP

process, informing the participant of service options in ways that are meaningful to the participant. This includes assessing the needs and desires of the participant, developing the person-centered service plan, and continuously updating and revising those plans as needs and desires change. The participant and their chosen representative(s) must be provided with written information from the waiver agency detailing the right to participate in the PCP process. Waiver agencies and direct service providers implement PCP in accordance with the MDHHS Person-Centered Planning Guideline document that may be found in the Directory Appendix of this Manual.

Waiver agencies shall have policy and procedures acknowledging the participant's authority to make decisions about the planning process and evaluate the PCSP and its outcomes.

SCs follow the principles of PCP, including providing opportunities for participants to express goals, desires, and expectations and supporting the involvement of allies to participate in planning activities.

SCs identify and discuss all potential supports and service options and emphasize participant choices and preferences.

The participant directs the PCP process. The process:

- Includes people chosen by the individual.
- Provides necessary information and support to ensure the participant directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
- Is timely and occurs at times and locations of convenience to the participant.
- Reflects cultural considerations of the participant and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participants.
- Offers choices to the participant regarding the services and supports the participant receives and from whom.
- Includes a method for the participant to request updates to the plan, as needed.
- Records the alternative home and community-based settings that were considered by the participant.

PCP meetings are conducted when the participant is not in crisis and at a time of the participant's choice. The participant has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process. An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the participant is not ready to fully participate in PCP. Interim care plans are authorized for no more than 30 days without a follow-up visit (or planning meeting) to determine the participant's status.

6.4.A.1. Participant Management of Risk

Participant management of risk embraces all the decisions one makes and activities one undertakes with the intent of improving one's health and safety and the environment. Each risk involves the possibility of detrimental consequences and their likelihoods. The management component of risk management involves decisions about these risks. State and federal government legislation and regulations make thousands of such decisions; families and individuals make millions of these decisions (National Quality Inventory Project, MS HCBS Waiver Programs for Individuals with Developmental Disabilities., Glossary). In MI Choice, effective risk management builds upon the service planning and monitoring processes.

CMS and MDHHS require waiver agencies to assist MI Choice participants in managing the risks associated with choosing home and community-based service programs over institutionalization. Risk management is part of assuring the health and welfare of MI Choice participants. "The identification of potential risks to waiver participants and the development of strategies to mitigate such risks are integral to enabling participants to live as they choose in the community while assuring their health and welfare. Critical risks should be addressed during the PCSP development process by incorporating strategies into the plan to mitigate whatever risks may be present" (CMS Instructions, Technical Guide and Review Criteria, Version 3.5 HCBS Waiver Application).

The SCs identify potential risks to the participant during all assessments and fully discuss these risks with the participant and their allies upon identification. During the PCP process, the participant specifies risks and preferred methods of monitoring their potential impact. Some participants may be in at-risk situations because of the absence of scheduled services that put the participant in a vulnerable state by compromising their health and welfare. Other risk situations include (but are not limited to) a structurally damaged or unsanitary environment or non-compliance with medical care. The iHC assessment system will automatically elicit some participant risks through the CAPs and triggers reports.

Waiver agencies may require participants to acknowledge when their choices pose risks for their health and welfare. MDHHS does not obligate the waiver agency to authorize services believed to be harmful to the participant. The SCs initiate negotiations of such issues in the PCP process. The SCs educate the participant to ensure the participant makes informed choices concerning their risks. The SCs inform service providers of a participant's risk status when ordering services in the traditional MI Choice program. The participant or, if preferred, the SC informs service providers of the participant's risk status when the participant chooses the self-determination. MDHHS requires agency providers, including waiver agencies, to have a contingency plan for emergencies that pose a serious threat to participant health and welfare (i.e., inclement weather, natural disasters, and unavailable caregiver.)

Each PCSP describes backup plans to implement when selected service providers are unable to furnish services as planned. This may involve developing lists of alternative qualified providers, using a provider agency or informal supports, or contacting the SC when planned services are unavailable. Additionally, the waiver agency develops an emergency plan with each participant that clearly describes a preferred course of action

when the participant has an emergency. SCs discuss and incorporate contingency plans into the individual PCSP during the PCP process.

MDHHS staff reviews a random sample of contingency plans during the clinical quality assurance review (CQAR) to ensure they meet participant needs and there is proper documentation for emergency, backup planning, and risk management procedures. The MI Choice Quality Improvement Strategy requires waiver agencies to monitor and track the activation of backup plans, including how well the plans worked in an effort to improve the development of backup plans with participants.

Clinical Assessment Protocols (CAPs) and Triggers

The iHC includes 27 CAPs that contain general guidelines for further assessment and individualized planning for participants when the iHC indicates problematic or "trigger" conditions. The iHC items identify participants who could benefit from further evaluation of specific problems and risks for functional decline. These items, known as triggers, link the iHC to a series of problem-oriented CAPs. Inter-RAI designed all CAPs to inform the clinical process. An average participant may trigger 10-14 of the 27 CAPs. Some of the CAPs form the core of the PCSP when relevant to the participant's existing problems and risks, others will not.

Waiver agencies may use a computerized report called the CAPs and Triggers Report (C&T report) that is generated following each assessment of a participant. SCs use the information on the C&T report to identify problems, evaluate causes and associated conditions for the problems, and to assist in the development of necessary goals and related approaches to services and referrals for services and supports. C&T reports also assist SCs with addressing and managing risks based upon the participant's identified individual risk factors. The in-depth evaluation of problems following the routine assessment helps SCs think through why a problem exists or why the participant is at risk, providing the necessary foundation on which to base the next steps in care planning to reduce risk.

The review of the C&T report requires SCs to evaluate a wide variety of triggered problems. The focus is not just on simple maintenance services or planning a response to an immediate problem. While these are included, the system also helps SCs to assess for opportunities to rehabilitate function, prevent decline, and maintain participant strengths. In responding to urgent needs, the participant and their SCs can identify service and support priorities. In looking at chronic problems, the participant and their SC can maintain comprehensive well-being. All risk planning and management is contingent on the participant and the participant’s family agreeing with the assessment and SC recommendations in care planning.

It is important to note that not all conditions triggered apply to every participant. The SC or participant may have already planned for, ameliorated, or determined a specific condition is not a problem to the participant. Conversely, the CAPs do not include every problem that the participant needs to have addressed in care planning and risk management. However, the CAPs are sound starting points covering most frequent problem situations that SCs need to address in care planning and risk management.

Service Need Levels Based on Identified Risks

SCs fully discuss strategies to mitigate risk with the participant and their allies, family, and relevant others during PCP. The SCs inform the participant of risks and educate the participant about consequences of chosen risks, as necessary. SCs document the participant's informed choice in the case record. SCs document participant-approved risk strategies and write them into the PCSP.

When a participant makes decisions that are self-injurious or jeopardize the safety of others, SCs determine if an appropriate substitute decision-maker can act informally or if they should seek a guardian to protect the participant. Waiver agencies must define a local procedure for taking such action.

SCs identify the service need level of each participant according to the Special Need Levels subsection of this chapter. SCs inform service providers of a participant's service need level when ordering services.

Waiver agencies maintain policy and procedures that address the use of restraints and seclusion of participants. SCs do not encourage the use of restraints by allies, but educate allies regarding alternative methods to address issues. Waiver agencies establish procedures that include:

- The use of alternative methods to avoid the use of restraints and seclusion;
- Methods used by SCs to detect the use of restraints;
- The protocols that SCs, service providers, and allies must follow when the use of restraints or seclusion are identified;
- The practices that must be employed to ensure the health and welfare of individuals; and
- Documentation that is required concerning the use of restraints or seclusion.

Contingency Planning

MDHHS requires direct providers of MI Choice services to have a contingency plan for emergencies that pose a serious threat to participant health and welfare (i.e., inclement weather, unavailable personal caregivers, etc.).

The development of contingency plans is one way to address some of the risks encountered by MI Choice participants. MDHHS identifies both emergency plans and backup plans as contingency plans for MI Choice participants. Contingency plans may be a single document that incorporates both the emergency plan and the backup plan. Waiver agencies assist all participants in the development of an effective contingency plan crafted to meet the unique needs and circumstances of each MI Choice participant. Waiver agencies must use the service need levels as identified and required in this chapter.

Waiver agencies retain a copy of each participant’s contingency plan in the participant record and provide additional copies to the participant, service providers, and other allies included in the plan, as preferred by the participant. The contingency plan is updated as

needed, and the waiver agency sends the participant, service providers, and other allies a copy of the contingency plan after each update.

Emergency Plans

- An emergency is a situation or event that places participant health or life in danger and requires immediate action or medical attention to prevent physical harm or hospitalization. Emergencies include natural disasters (tornados, floods, drought, heat waves, blizzards, etc.), unnatural disasters (fires, bomb threats, terrorism, etc.), and sudden onset of medical crises.
- The waiver agency encourages participants to use a PERS or dial "911" during an emergency.
- Participants whose life depends upon equipment that requires electricity have an emergency plan that addresses what to do during a power outage, or clearly states the participant's preference not to include such measures.
- Participants who need assistance to ambulate have an emergency plan that includes the notification of someone who will assist them in evacuating their residence if necessary, or clearly state the participant's preference not to include such measures.
- MDHHS urges all participants to have escape routes defined for various disasters.
- MDHHS urges all waiver agencies to be involved with law enforcement officials and other disaster preparedness agencies at the local level to help these agencies identify and assist MI Choice participants during emergencies.

Backup Plans

- Backup plans provide for alternative arrangements for the delivery of services that are critical to participant well-being in the event that the provider responsible for furnishing the services fails or is unable to deliver them (CMS Instructions, Technical Guide, and Review Criteria, Version 3.5 HCBS Waiver Application). Backup plans are employed when scheduled providers do not show up as expected.
- Each contracted service provider shall have established policies and procedures that reasonably ensure the delivery of services to participants in the event that the regularly scheduled provider is unable to furnish the service.
- The waiver agency notifies providers of the participant's service need level. This information shall also be included in the backup plan for each participant.
- Backup plans should minimally include contact information for all providers furnishing critical services to the participant. A critical service is a service the participant must receive as planned and as specified in the service need level of the participant.
- Backup plans should include methods for the participant and provider agency to contact the SC if a provider does not deliver a service as planned.
- Backup plans should include provisions for furnishing services when an unpaid caregiver is unable to provide a service that is critical to the participant and usually provided by that ally.

- Backup plans should clearly state the participant's preferences for receiving services and supports if the regularly scheduled provider cannot furnish the services and supports. Waiver agencies develop policies and procedures to track the following:
  - When backup plans are activated;
  - When the backup service provider furnished services; and
  - When service is not provided following activation of backup plans.

6.4.B. PERSON-CENTERED SERVICE PLAN [CHANGE MADE 7/1/2025]

The participant's PCSP is an individualized, comprehensive document developed by the participant, their chosen representative(s), and the supports coordinator prior to the provision of services. Using a person-centered process, waiver agencies must establish a written PCSP for each participant that identifies the participant's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. This document includes all services provided to, or needed by, the participant regardless of funding source. An initial PCSP must be completed within 10 days of the program enrollment date. The full PCSP is developed when the participant is not in crisis and may build upon an interim care plan, but should be completed within 90 days of MI Choice enrollment. The participant must approve all services and interventions before implementation and the waiver agency must document participant approval. MI Choice services must be stipulated in the PCP process and the participant assessment. Requirements for the PCSP are defined in the Home and Community Based Services Chapter of this Manual.

Using a person-centered planning process, each waiver agency must establish a written person-centered service plan (PCSP) for each participant based upon the assessment of needs, goals, and preferences. The waiver agency and participant must develop the PCSP before providing services. The participant must approve of all services in the PCSP. The waiver agency must document participant approval on the PCSP.

The PCSP must contain, at a minimum:

- The individual chose the setting in which they reside
- The services and supports that are important to the individual to meet the needs identified during the individual's assessment
- The individual's strengths and preferences
- The clinical and support needs identified by a functional assessment
- The amount of service authorized
- The frequency and duration of each service, and the individual's preference for receiving those services and supports
- Units of each service per visit and per week
- Cost per unit
- Total cost of service plan
- Start and stop dates for each service

- The type of provider to furnish each service
- Participant-focused goals and outcomes
- For participants receiving home-delivered meals, notations regarding the number of meals served per day, the days of service, and special diet orders or requests
- Risk factors and measures identified to mitigate them
- Individuals responsible for monitoring the plan
- The informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation

Informal Supports are unpaid supports that choose to volunteer their time to assist participants in lieu of MI Choice services and supports. **(text added 7/1/2025)** If informal supports are involved as providers of services, they are not required to sign the PCSP, but must be notified about the duties they are expected to perform for the participant. The participant or legal representative takes responsibility for ensuring these duties are completed and must sign the PCSP indicating they are accepting the responsibility. If the participant or legal representative has not had the discussion with the informal support(s), and prefers the supports coordinator to follow up with the informal support(s), the supports coordinator must do so and document this in the PCSP. If the informal supports are unable to carry out their responsibilities, or the supports coordinator notices during a home visit that the duties have not been performed, the supports coordinator will notify the informal support(s) of the duty to be performed. If the informal support cannot be reached, or refuses to perform the duty, the supports coordinator will discuss other arrangements (formal or informal) with the participant and legal representative. Documentation in the PCSP must be done in a place that is carried from one PCSP update to the next.

The PCSP reflects the SC's authorization to implement participant-approved services. The SC updates the PCSP as frequently as necessary or preferred, but at least every 90 days after the initial assessment, then 180 days after that or as desired by the participant and documented in the PCSP.

6.5 Service Access

SCs and participants arrange and/or purchase in-home health and social services and supports established in the approved PCSP. SCs provide education of participant options in receiving services and supports.

6.6 Follow-Up and Monitoring

Follow-up and monitoring include contact between SCs, the participant or service providers to ensure providers deliver services as planned and to the satisfaction of the participant. SCs use follow-up and monitoring to evaluate the timeliness, appropriateness, and quality of services implemented under the PCSP. SCs monitor all services implemented on behalf of participants as a function of care planning and participant reassessment activities.

Waiver agencies must maintain local policy and procedures, assuring that participants have a continuous opportunity to provide feedback about services, supports, interventions, and treatments.

SCs must contact participants as determined by the participant in their PCSP (usually about every 30 days) to monitor the participant's health and welfare, the provision of services (including verification of the delivery of one-time services), and the participant's satisfaction with the current PCSP. SCs and participants can adjust services at this time to serve the participant better. SCs should contact the participant no less frequently than every 90 days, unless the participant chooses otherwise.

SCs must contact newly enrolled participants within 14 days of the agreed upon service start date to verify the providers deliver services in the manner arranged and to the satisfaction of the participant. SCs may contact the service provider in addition to contacting the participant to verify the provision of services and any issues identified by the provider. This requirement does not apply to changed services or participants who are re-enrolling in the MI Choice program after a brief disenrollment period.

For participants who enroll in MI Choice upon discharge from a nursing facility or hospital, the supports coordinator must ensure the participant's necessary services or supplies are in place prior to discharge. After the participant's discharge, the supports coordinator must contact the participant within 24 hours of discharge to ensure immediate needs are being met. Within seven (7) days of the discharge, the supports coordinator must conduct an in-person meeting (home visit) with the participant to ensure the previous assessment is still valid, and update as necessary. A full reassessment may be done at that time if the situation warrants it.

An in-person meeting (home visit) must be completed within seven (7) days of a participant moving/transferring from one residence to another (not nursing facility or hospital) to ensure that the participant's needs are being met and to update any assessments as necessary.

SCs must record changes in services negotiated during follow-up and monitoring on behalf of participants in the participant's PCSP.

SCs must provide oral or written feedback to providers regarding services furnished according to the PCSP when the SC receives complaints from participants.

When SCs attempt to arrange a service that cannot start within 30 days, they must contact the provider agency every 30 days until a provider can implement the service. When a network provider is not available, the waiver agency must use an out-of-network provider to furnish approved services until an in-network provider is secured.

SCs must contact participants to ensure that responsible parties implement plans of service as written and according to participant preferences.

Waiver agencies have written complaint procedures to monitor, investigate, and follow-up on concerns expressed by participants. The primary objective of the complaint procedure is for the waiver agency to resolve concerns to the satisfaction of the participant. Each waiver agency maintains a complaint file separate from complaint content logged into individual case records.

Follow-up and monitoring must be conducted by a SC or someone who otherwise meets the qualifications to be a SC (i.e., is a licensed nurse or social worker) and is acting as a SC in the absence of the participant's assigned SC. Examples of acting in the absence of the participant's assigned SC include situations where the assigned SC is on vacation, sick leave, medical leave, or has permanently left the waiver agency and another SC has not yet been assigned.

6.7 Reassessment

Reassessment provides a scheduled, periodic face-to-face reexamination of participant functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the participant PCSP. Either an interdisciplinary SC team or an individual SC can perform reassessments using the iHC. A team is not required to perform reassessments.

SCs must provide a face-to-face reassessment to program participants within 90 days of the initial assessment or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver). Reassessments may be completed virtually (audiovisual) only if the participant chooses that method.

SCs must provide a subsequent face-to-face annual reassessment to participants or sooner when there are significant changes in the participant's health or functional status, or significant changes in the participant's network of allies (i.e., death of a primary caregiver).

The reassessment is comprehensive and includes review of the same items evaluated during the previous assessment.

The SC may only copy and paste information that has not changed from a previous assessment to the new assessment when the information is still relevant.

The case record must reflect documentation that the participant continually meets the LOCD. The record must indicate the appropriate door through which the participant meets the LOCD criteria based upon the current assessment. If the SC does not complete a paper copy of the LOCD determination tool, the corresponding iHC assessment data MUST support the door through which the SC indicates the participant meets LOCD criteria.

The SC reviews reassessment findings with the participant. The SC and the participant update the PCSP, if necessary, based on mutually agreed upon service changes. The participant approves each service change. The SC sends appropriate notice to the participant and, when necessary, obtains a clearly written, signed statement from the participant that acknowledges the agreed upon change before service changes can be put into place.

When one SC completes an assessment, that SC should consult with an SC of the other discipline to ensure all relevant issues have been updated and properly addressed.

When one SC completes an assessment and identifies participant issues that would be better addressed by the other discipline, OR when the other discipline reviewed the assessment completed by a single SC and identified additional issues, a SC from the other discipline shall do the following in collaboration with the other SC and discuss with a supervisor:

- Perform follow up with the first SC to ensure the record properly addresses the issues, AND
- When indicated by professional judgment as the best course of action, contact the participant to ensure the issues are properly captured within the record and update the PCSP as needed, OR
- When indicated by professional judgment as the best course of action, conduct another in-person reassessment within the next seven days to verify the first SC's findings and ensure the record properly reflects and addresses all issues.

The SC includes reassessments in the participant case record.

Participants may refuse reassessment. SCs document this refusal in the case record. However, to maintain program eligibility, the waiver agency must assess all program participants on an annual basis.

MDHHS requires electronic data collection for all assessments completed for MI Choice participants. SCs must input all assessment data into an electronic system, such as COMPASS. The data system must record the date of and person responsible for any additional information put in the record or changes made to the original assessment data collected.

The SC also documents that the participant continues to meet the nursing facility level of care within the case record, specifying the appropriate "door" through which the participant meets level of care criteria. If a supports coordinator suspects the participant no longer meets the nursing facility level of care, the supports coordinator must conduct a face-to-face LOCD and input the data into the LOCD application in CHAMPS. When CHAMPS confirms the individual no longer meets LOCD criteria, the supports coordinator initiates program discharge procedures and provides the participant with notice and information on appeal rights. A refusal which prevents a timely redetermination is cause for termination from the program.

SECTION 7 – ADMINISTRATION

MDHHS serves as the single state agency in the operation of the MI Choice program. MDHHS contracts with entities to administer the program throughout the state. Certain administrative functions are assigned to the local agencies as defined in the Medicaid waiver application to CMS, as renewed and amended. To assist MDHHS in operating MI Choice, agencies are required to submit periodic reports as detailed in this section.

7.1 WAIVER AGENCIES AS PREPAID AMBULATORY HEALTH PLANS

MDHHS contracts with waiver agencies that operate as PAHPs to perform administrative functions. They are responsible for disseminating waiver information to applicants, assisting applicants with waiver enrollment (which includes assisting applicants with completion of the Medicaid application to secure financial eligibility), managing waiver enrollment against approved limits, monitoring expenditures against approved limits, conducting assessments and LOCD evaluations, reviewing person-centered service plans to ensure that waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

Each waiver agency must sign a provider contract with MDHHS assuring that it meets all program requirements.

Waiver agencies are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit or for-profit organizations that provide services meeting established service standards, certifications or licensure requirements. Participants may only use providers in the waiver agency's provider network, unless no willing provider is available within the waiver agency's network. Waiver agencies must ensure MI Choice services identified in the person-centered service plan are furnished according to the plan, which may include utilizing providers outside of the provider network, as specified in 42 CFR §438.206, until such time as a network provider is able to furnish the service.

7.2 WAITING LIST REPORTING

Waiting list data is collected and maintained on a secure, web-based application. Waiver agencies must complete all required fields for each qualified MI Choice applicant. Waiting list data must be entered online within one business day after completion of the MI Choice Intake Guidelines. If an applicant is removed from the MI Choice waiting list, the data must be completed online within five business days and include the reason for removal.

7.3 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

All MI Choice waiver agencies and providers are required to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any subsequent revisions. Compliance is required in areas that include privacy and security rules, data sharing, and disclosure.

7.4 TRANSFERRING MI CHOICE PARTICIPANTS TO ANOTHER WAIVER AGENCY

MDHHS ensures participants have a choice of a waiver agency, as available, to coordinate MI Choice services. A participant may choose to transfer enrollment from one waiver agency to another, as available within the region where they live, or a participant may move to another region of the State.

Waiver agencies are responsible for managing transfers of participants to other agencies or accepting transfers from another agency and are required to:

- Ensure that participants are transferred from one agency to another, preserving continuity of care and the integrity of the participant's preferences and PCSP.
- The new waiver agency must perform an initial assessment. This may include an LOCD if an active LOCD is not available in CHAMPS or the participant has significant changes. The new waiver agency must either enter an LOCD in CHAMPS or adopt the current LOCD as specified in LOCD policy for the transferred participant within 14 calendar days after the date of the participant's enrollment in the new waiver agency's program, or otherwise according to MDHHS LOCD policy.
- The new waiver agency for each transferred participant must not reimburse providers for delivered MI Choice services authorized by a previous waiver agency. The new waiver agency reviews PCSP activity and authorizes a new PCSP with the participant.

The waiver agency the participant transferred from is responsible for closing the participant enrollment at that agency so that the new agency can enroll the participant in its MI Choice program. The waiver agency the participant transferred from is responsible for entering disenrollment information in CHAMPS so that the waiver agency the participant is transferring to may enter enrollment information in CHAMPS.

7.5 Release of Information and Consent

The participant shall authorize the use or disclosure of PHI under HIPAA by signing a Release of Information and Consent Form (ROI). The ROI shall include the following information:

- Permission to use or disclose PHI for purposes beyond treatment, payment, or health care operations.
- A description of the PHI to be disclosed.
- The purpose for the disclosure.
- The intended recipient(s).
- The participant's right to withdraw consent of release at any time.
- The date the authorization expires, not to exceed one year from the date of participant signature.
- Participant or legal representative signature and date. A relative or other representative may only sign the release when the participant is determined legally incompetent or is physically unable. The case record must clearly document why participants cannot sign the ROI themselves.
- The signature and date of SC completing the form.

7.6 Case Record Requirements

Waiver agencies and their service providers maintain participant records, including assessments, plans of service, service or contact logs, reassessment, and quality assurance records for a period of not less than ten years to support an audit trail. This includes maintenance of a Health Information System (HIS) that will collect, analyze, integrate, and report data as required within the MI Choice Contract and all attachments. The case record may exist in an electronic format. MDHHS does not require waiver

agencies that maintain case information in electronic format to maintain hard copy case records. However, the waiver agency must make electronic case records available to MDHHS or other reviewers when conducting audits and other authorized reviews.

7.6.A. Case Records

Each enrolled MI Choice participant has an individual case record. All forms required in the case record must be properly completed according to policy or form instructions. The case record shall include, but is not limited to, the following required information:

- NF LOC determination results
- Assessments and reassessments
- Freedom of choice form, participant consent to enroll
- Participant consents to release confidential information
- Plans of service and service plans
- Work orders and instructions to providers
- Progress notes, contact logs or other notes that serve as a log-in documenting pertinent contacts with participants, providers and others involved with furnishing services and supports to the participant
- Any correspondence pertaining to the services and supports provided to a participant
- Transfer and closure documentation

Additional requirements for case records include:

- Waiver agencies maintain MI Choice case records in a manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow up.
- Writers enter hard copy case record information in ink.
- Electronic Health Records (EHR) or Health Information Systems (HIS) (such as MICIS, COMPASS, or other systems for collecting case record documentation electronically) must have a method to lock records upon submission of data into the EHR that conforms to industry standards. The system must track all changes made to all information entered into the system including the date, time, and user making the change.
- Waiver agency staff either signs or initials each entry in the case record. When using initials, the waiver agency maintains a signature log sheet with employees' names and initials. EHR shall record the user information for data entered in the case record.
- Writers make corrections to case record entries by drawing a line through the incorrect information and entering corrected information above, below or adjacent to the previous entry. Whether written or electronic, under no circumstances shall information included in the case record be permanently erased. Electronic records shall include a method to correct information without erasing that information, such as using a strikethrough font. Additionally, electronic records shall include a backup system to retrieve any lost data due to system errors.

- Writers identify late entries. MDHHS allows waiver agencies to make late entries in the case record as long as the writer notes that they made the entry sometime after the contact occurred. Writers may not enter previously omitted information as a late entry more than seven (7) days after the contact occurred (see how to amend a record below).
- Writers may amend the record at any time by identifying an entry as a record amendment and describing previously omitted information. This type of entry should describe why the entry is being made (i.e., after peer or supervisory review) and who is making the amendment.
- Writers may add entries to the record to correct earlier entries of electronic records that contained erroneous or inaccurate information.
- Only the person that entered the original data into the EHR may edit that data. If this is not possible, other users may include a corrective note in the EHR that explains the error in the original data but may not change the original data.
- The system must date and time stamp all EHR entries and include the username under which the entry was made. The agency must keep a list of all usernames and the identification of the individual associated with that username.
- Waiver agencies maintain a copy of participant enrollment files to support capitated payments made through CHAMPS.
- Waiver agencies maintain a record of payments made to providers.
- Waiver agencies monitor contractors and subcontractor activity and maintain records and reports of the reviews and findings.
- Waiver agencies maintain necessary records that disclose fully the extent of service provided to each participant for a period of ten (10) years for the purpose of subsequent audit.

SECTION 8 – FINANCING AND REIMBURSEMENT

Annual funding levels for MI Choice are subject to appropriation allocations made by the Michigan Legislature. MDHHS contracts annually with waiver agencies to operate the MI Choice program, and all waiver agency budget and reimbursement requirements and considerations must be defined in the contract, as amended. Any additional consideration or compensation to the waiver agency must also be included in the annual contract, as amended. Waiver agencies are paid through capitation payments and are required to submit all encounter data to MDHHS as outlined in the Encounter Data Reporting subsection of this chapter. Encounter data is processed through CHAMPS. Waiver agencies are required to submit all financial reports as detailed in the annual contract. Each agency is subject to review or audit by MDHHS, the State of Michigan, or their designee.

Medicaid is established as the payer of last resort. Waiver agencies must pursue and secure all third party liability (TPL) sources possible. Agencies must make every effort to enroll and utilize dually certified (Medicare and Medicaid) providers. Agencies cannot use waiver funds for services that are covered through another payment source.

8.1 STATE REIMBURSEMENT TO WAIVER AGENCIES

The State reimburses waiver agencies based on the rates and conditions stated in the contract. MDHHS establishes, and CMS approves, capitation rates for MI Choice participants. The capitation payment is comprehensive and covers both administrative and service costs associated with each person enrolled in MI Choice.

Capitation payments will be processed through files generated in CHAMPS on a monthly basis. This file contains an electronic listing of individuals who are enrolled in the MI Choice program with each waiver agency. The Medicaid Management Information System (MMIS) then performs quality checks, including:

- Verification of current Medicaid eligibility;
- A valid LOCD indicating the participant meets nursing facility level of care; and
- The participant is not enrolled in any other long-term care program.

Payment to waiver agencies will occur through an electronic funds transfer on the fourth Wednesday of the month. This payment will be available to waiver agencies on the Thursday following the fourth Wednesday of the month.

Waiver agencies and providers accept Medicaid payment as payment in full for services rendered, unless the State makes an exception to this requirement. In addition, MDHHS requires waiver agencies to have policies and procedures to ensure that waiver agencies and their providers do not seek or accept additional or supplemental payment from participants and their allies or representatives for MI Choice services.

8.2 ENCOUNTER DATA REPORTING

Each waiver agency must submit all encounter data to MDHHS within 180 calendar days of the date that services were rendered. Waiver agencies must resolve issues related to encounters that are rejected by CHAMPS within 30 calendar days of notification by MDHHS or its designee. Agencies have 10 calendar days after the expiration of the 30-day resolution window to report on issues that cannot be resolved.

8.3 Administrative Expense and Other Financial Reporting

Each waiver agency must submit an Administrative Expense Report (AER) to MDHHS as specified in the Contract. The expenses reported must be actual expenses incurred by the waiver agency. Each AER shall cover one calendar month and is due within 30 calendar days after the conclusion of that month. Waiver agencies must submit additional financial reports and information as requested by MDHHS. MDHHS must communicate requirements for such additional information to the waiver agency in writing and allow sufficient time for a response.

8.4 Financial Audit Requirements

MI Choice waiver agencies are contractually obligated to comply with, and ensure compliance by, its subcontractors with all requirements of the Single Audit Act and any amendments to this act. Waiver agencies must submit to MDHHS a Single Audit, Financial Statement Audit, or Audit Status Notification Letter. If submitting a Single Audit or Financial Statement Audit, waiver agencies must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs and a management letter (if issued) with a response.

Waiver agencies that expend $750,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Title 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

Waiver agencies exempt from the Single Audit requirements that receive $750,000 or more in total funding from MDHHS in state and federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with Generally Accepted Auditing Standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than $750,000 of total MDHHS grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDHHS-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template for the Audit Status Notification Letter and further instructions are available on the MDHHS website. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response, or Audit Status Notification Letter) must be submitted within nine months following the end of the contractor's fiscal year to MDHHS.

Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and E.

SECTION 9 – PROVIDERS

Authorization for provision of waiver services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

9.1 ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR §434.6 to purchase services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in this Chapter and the MI Choice Contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

To ensure network capacity, as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service and at least two providers for each MI Choice service. When waiver agencies cannot ensure this choice within 30 miles or 30 minutes travel time for each participant, they may request a rural area exception from MDHHS.

9.2 FAMILY MEMBERS AS SERVICE PROVIDERS

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify their preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the person-centered service plan and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the person-centered service plan, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

9.3 REIMBURSEMENT RATES FOR PROVIDERS

Each waiver agency is responsible for sub-contracting with provider entities and for ensuring access to services. The process of rate determination for providers resides in the contract negotiation between the waiver agency and the provider. MDHHS does not play a role in this process.

Rates paid for services provided through the waiver must be adequate to ensure access to services needed by participants.

9.4 CRIMINAL HISTORY REVIEWS

Each waiver agency and direct provider of home-based services must conduct a criminal history review through the Michigan State Police for each paid staff or volunteer who will be entering a participant's residence. The waiver agency and direct provider shall have completed reference and criminal history checks before authorizing an employee or volunteer to furnish services in a participant's residence. The scope of the investigation is statewide.

Both waiver agencies and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history checks have been conducted in compliance with operating standards. Waiver agencies must comply with additional criminal history reviews mandated by the State for home and community-based services providers.

Waiver agencies must also check the MDHHS Sanctioned Providers List and must not contract with any providers on this list for the duration of the sanction period until approved by MDHHS to resume providing services. The MDHHS Sanctioned Provider List is located on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.5 Use of Restraints, Seclusion or Restrictive Interventions

Providers are prohibited from using seclusion or restrictive interventions in addition to using restraints. Qualified reviewers conduct Clinical Quality Assurance Reviews and home visits which include a discovery process to examine the use of restraints, seclusion or restrictive interventions by family or caregivers. Supports coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions.

An exception to restraints or restrictive intervention is bed rails or bed canes. If bed rails or bed canes are used, this must be based upon assessed need for the participant and documented in the person-centered service plan. If the participant resides in a provider-controlled setting, there must be an order from a licensed medical professional, and this must be kept on file in the participant's case record at the waiver agency. As per requirements in federal law and the Home and Community-Based Services Chapter in this Manual, the use of bed rails or bed canes must be reviewed on an annual basis to ensure they are still required. If no longer required, the bed rail or bed cane must be removed.

9.6 Contributions

Neither the waiver agency nor any service provider under contract with the waiver agency may require monetary donations from participants of the MI Choice waiver program as a condition of participation in the MI Choice waiver.

The waiver agency and each direct service provider must accept MI Choice payments for services as payment in full for such services. Consistent with the Code of Federal Regulations, Chapter 42, Section 438.60 (42 CFR §438.60), service providers must not seek nor receive payment other than payment from the waiver agency for services covered under the Contract between MDHHS and the waiver agency, except when these payments are specifically required to be made by the State in Title XIX of the Social Security Act, in 42 CFR chapter IV, or when MDHHS makes direct payments to service providers for graduate medical education costs approved under the State Plan.

No paid or volunteer staff person of a direct service provider may solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

9.7 Confidentiality

Each waiver agency and direct service provider must have procedures to protect the confidentiality of information about participants or persons seeking services collected in the conduct of its responsibilities. The procedures must ensure that no information about a participant or person seeking services, or

obtained from a participant or person seeking services by a service provider, is disclosed in a form that identifies the person without the informed consent of that person or of their legal representative. However, disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of the client information), so long as access is in conformity with the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996. Waiver agencies and direct service providers must maintain all client information in controlled access files. This requirement applies to all protected information whether written, electronic, or oral.

9.8 Compliance with Home and Community Based Services Settings Requirements

Each waiver agency and direct service provider must comply with the Federal Home and Community Based Services Settings Requirements as specified in 42 CFR §441.301(c)(4) as well as in the Home and Community-Based Services Chapter of this Manual. Direct service providers with subcontracts secured prior to March 17, 2019 must be fully compliant with this regulation by March 17, 2019, unless they are included in the heightened scrutiny process. All direct service providers added to the waiver agency's provider network after March 17, 2019 must be compliant with this ruling before the direct service provider may furnish services to a waiver participant.

MDHHS will use the following process to ensure compliance to this requirement:

- Each waiver agency will assess all applicable providers annually using a MDHHS-approved survey. In some situations described below within this section, the results of the surveys will be submitted electronically to MDHHS for a determination of compliance to the requirements.
- MDHHS will notify both the provider and the MI Choice waiver agency regarding the provider's compliance based upon the completed survey tool that was submitted to MDHHS.
- For providers who are non-compliant, the provider will have one to two weeks to correct all issues that cause the non-compliance.
- Once the issues are corrected, the provider will notify the waiver agency and schedule another on-site survey.
- The waiver agency will have one to two weeks to complete another on-site survey and submit the survey to MDHHS for review within 10 days of the visit.
- If a provider does not contact the waiver agency within one to two weeks, the waiver agency will contact the provider to determine progress on the corrective action and schedule another on-site visit accordingly.
- If the provider has not satisfactorily resolved the compliance issues, the waiver agency will suspend the provider from receiving new MI Choice participants until such time as the provider comes into compliance.
- Some providers may require Heightened Scrutiny to determine compliance. These providers will follow the Heightened Scrutiny Process defined by MDHHS to ensure compliance and to continue participation with the MI Choice program.
- Regardless of the original notification date, all providers in all MI Choice provider networks will be compliant with the ruling no later than March 17, 2019, or the date approved in the State Transition Plan, whichever is sooner.

- Waiver agencies must have completed person-centered transition plans with individuals served by non-compliant providers before March 17, 2019.
- By March 17, 2019, no MI Choice participants will be served by non-compliant providers, and all non-compliant providers will be removed from the MI Choice provider network.
- For MI Choice participants residing in a provider-owned and controlled setting, the waiver agency must keep a copy of the lease agreement and resident care agreement on file.

9.9 Notifying Participant of Rights

Each waiver agency or direct provider of home-based services must notify each participant, in writing, at the initiation of service of their right to comment about service provision or appeal the denial, reduction, suspension, or termination of services. Such notice must also advise the participant that they may file complaints of discrimination with the respective waiver agency, the Department of Health and Human Services Office of Civil Rights, or the Michigan Department of Civil Rights. The MI Choice Participant Handbook meets this requirement.

9.10 Selection of a Provider to Furnish Services

The waiver agency works with participants to select service providers as needed on an individual basis according to the following criteria:

- Participant Preference: Participant has a provider preference.
- Cost: The cost of services is a factor in selecting a service provider.
- Accessibility: Practical considerations involved in selecting a provider include the provider's geographic area of service and ease of service delivery to the participant.
- Ability to provide quality service: The waiver agency considers the provider's past performance in furnishing quality services as authorized in the participant's PCSP. Quality includes performance, participant outcome, and accountability as monitored by the waiver agency.
- Comprehensive Care: The waiver agency makes a reasonable effort to minimize the number of different agencies involved in providing services to each participant to limit participant and family stress. The waiver agency considers the ability of the provider to furnish the different types of services needed by each participant when ordering services.

9.11 Additional General Requirements for Providers

- Waiver agencies have policies and procedures to identify and prevent problems with access to MI Choice services. Access issues include, but are not limited to, problems with provider availability and adherence to the participant approved PCSP.
- Waiver agencies and service providers enter into contractual agreements that include required assurances for nondiscrimination, minimum provider service standards, and contract requirements included in 42 CFR §434, 42 CFR §438, and the MDHHS Medical Services Administration (MSA) provider enrollment agreement.
- The waiver agency maintains written minimum service standards for MI Choice services that fulfill licensure and certification requirements mandated by CMS and that comply with the CMS-

approved MI Choice waiver application and the MDHHS Minimum Operating Standards for MI Choice Services.

- The waiver agency has written procedures to secure competitive, per unit rate agreements from qualified service providers.
- The provider enrollment process includes a description of the frequency and method of verifying and monitoring staff qualifications and how the waiver agency documents this verification. MDHHS defines a willing provider as a provider who agrees to accept Medicaid payment as payment in full for rendering a service, abides by all other Medicaid provider requirements, including executing provider agreements, and adheres to the required service standards.
- Waiver agencies must allow Medicaid beneficiaries to select from any qualified provider within the waiver agency's provider network.
- Waiver agencies must provide MI Choice services to any participant who needs the service. Waiver agencies may not limit the number of MI Choice participants who receive a service or deny a needed MI Choice service for any reason (e.g., lack of funds). Waiver agencies must make MI Choice services available on a comparable basis to all MI Choice participants based on need.
- The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. PCS provided through MI Choice must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

Waiver agencies have policy and procedures for identifying, documenting, and addressing noncompliance by providers. This includes identification of the persons responsible for taking appropriate action with providers who continually demonstrate poor performance or who are not qualified to provide services.

9.12 Home-Based Services Providers

MI Choice waiver home-based services include community living supports, respite services provided in the home, chore services, personal emergency response systems, private duty nursing/respiratory care, nursing services, counseling, home delivered meals, training services, and community health workers.

9.12.A. Participant Assessments

Direct providers of home-based services must avoid duplicating assessments of individual participants to the maximum extent possible. Home-based service providers must accept assessments conducted by waiver agencies and initiate home-based services without having to conduct a separate assessment unless there is a legitimate reason to conduct the separate assessment. Waiver agencies must make every attempt to supply direct providers of home-based services with enough information about each participant served by that organization to provide needed services properly.

9.12.B. Supervision of Direct-Care Workers

Home-based service providers must always have a supervisor available to direct care workers while the worker is furnishing services to MI Choice participants. The provider

may offer supervisor availability by telephone. Home-based service providers must conduct in-home supervision of their staff at least twice each fiscal year. A qualified professional must conduct the supervisory visit.

9.12.C. Participant Records

Each direct provider of home-based services must maintain comprehensive and complete participant records that contain, at a minimum:

- Details of the request to provide services.
- A copy of the waiver agency's evaluation of the participant's need (this may be appropriate portions of the MI Choice assessment or reassessment).
- Service authorizations or work orders.
- Providers with multiple sources of funding must specifically identify waiver participants; records must contain a listing of all dates of service for each participant and the number of units provided during each visit.
- Notes in response to participant, family, and agency contacts (not required for home-delivered meal programs).
- A record of release of any personal information about the participant and a copy of a signed release of information form.

Direct providers of home-based services must keep all participant records (written, electronic, or other) confidential in controlled access files for a minimum of 10 years.

9.12.D. In-Service Training

Staff of waiver agencies and direct providers of home-based services must receive in-service training at least twice each fiscal year. Waiver agencies and providers must design the training so that it increases staff knowledge and understanding of the program and its participants, and improves staff skills at tasks performed in the provision of services. Waiver agencies and direct providers of home-based services must maintain comprehensive records identifying dates of training and topics covered in an agency training log or in each employee's personnel file. The employer must develop an individualized in-service training plan for each employee when performance evaluations indicate a need.

9.12.E. Additional Conditions and Qualifications

Each waiver agency and direct provider of home-based services will assure MDHHS that employees or volunteers who enter and work within participant homes abide by the following additional conditions and qualifications:

- Service providers must have procedures in place for obtaining participant signatures on the time sheets (or similar document) of direct care workers to verify the direct service worker provided the work ordered by the waiver agency. Electronic Visit Verification (EVV) systems may take the place of this requirement as long as the verification is

available to the waiver agency. If providers are utilizing EVV systems, paper time sheets are not needed.

- Direct service workers are prohibited from smoking in participant's homes.
- Direct service workers must demonstrate the ability to communicate adequately and appropriately, both orally and in writing, with their employers and the MI Choice participants they serve. This includes the ability to follow product instructions properly in carrying out direct service responsibilities (i.e., read grocery lists, identify items on grocery lists, and safely use cleaning and cooking products).
- Direct service workers must not use their cell phones for personal use while in a participant's home. Exceptions may be made in cases of emergency. Direct service workers should engage with the participants while furnishing the services specified on the person-centered service plan.
- Direct service workers must not threaten or coerce participants in any way. Failure to meet this standard is grounds for immediate discharge.
- Waiver agencies will inform service contractors and direct service workers promptly of new service standards or any changes to current services standards.

9.13 Insurance Coverage

Each waiver agency and direct service provider must have sufficient insurance to indemnify loss of federal, state, and local resources due to casualty or fraud. Insurance coverage sufficient to reimburse MDHHS or the waiver agency for the fair market value of the asset at the time of loss must cover all buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by MDHHS. The following insurances are required for each waiver agency or direct service provider:

- Worker's compensation
- Unemployment
- Property and theft coverage
- Fidelity bonding (for persons handling cash)
- No-fault vehicle insurance (for agency-owned vehicles)
- General liability and hazard insurance (including facilities coverage)

MDHHS recommends the following insurances for additional agency protection:

- Insurance to protect the waiver agency or direct service provider from claims against waiver agency or direct service provider drivers and/or passengers
- Professional liability (both individual and corporate)
- Umbrella liability
- Errors and Omission Insurance for Board members and officers
- Special multi-peril
- Reinsurance/Stop-loss insurance

9.14 Volunteers

Each waiver agency or direct service provider utilizing volunteers must have a written procedure governing the recruiting, training, and supervising of volunteers. Volunteers must receive a written position description, orientation, training, and a yearly performance evaluation, if appropriate.

9.15 Staffing

Each waiver agency or direct service provider must employ competent personnel who have the necessary skills to provide quality supports and services to participants at levels sufficient to provide services pursuant to the contractual agreement. Each waiver agency or direct service provider must demonstrate an organizational structure including established lines of authority. Each direct service provider must identify a contact person with whom the waiver agency can discuss work orders and service delivery schedules or problems.

9.16 Staff Identification

Every waiver agency or direct service provider staff person, paid or volunteer, who enters a participant's home must display proper identification. Proper identification may consist of either an agency picture card or a Michigan driver's license and some other form of agency identification.

9.17 Orientation and Training Participation

New waiver agency or direct service provider staff must receive an orientation training that includes, at a minimum:

- Introduction to the MI Choice waiver;
- The waiver agency's grievance and appeal process;
- Maintenance of records and files (as appropriate);
- Emergency procedures;
- Assessment and observation skills; and
- Ethics, specifically:
  - Acceptable work ethics
  - Honoring the MI Choice participant's dignity
  - Respect of the MI Choice participant and their property
  - Prevention of theft of the MI Choice participant's belongings.

Employers must maintain records detailing dates of training and topics covered in employee personnel files.

Waiver agencies and/or direct service providers must ensure that each employee has the support and training needed to competently and confidently deliver services to participants prior to working with each participant. Waiver agency or direct service provider staff must participate in relevant in-service training as appropriate and feasible. Some MI Choice services have specific requirements for in-service training. When applicable, the service standard stipulates the required in-service training topics.

9.18 Record Retention

Each waiver agency and direct service provider must keep all records related to or generated from the provision of services to waiver participants for not less than 10 years.

9.19 Waiver Agent Billing and Payments

9.19.A. Billing Procedures

- Providers of MI Choice services submit bills to the waiver agency detailing the date of service, the type of service, the unit cost, and the total number of units provided for each MI Choice participant served.
- Waiver agencies specify in provider contracts the acceptable amount of time from date of service that providers may send bills to the waiver agency in order to receive payment for services rendered.
- Waiver agencies match and verify provider bills against the participant's approved PCSP using MICIS, COMPASS, or a compatible data system.
- Waiver agencies have written procedures regarding the billing process.

9.19.B. Provider Payments

- Waiver agencies process payment for all verified bills submitted by providers.
- Waiver agencies make payments only for services authorized within the PCSP and delivered to the participant.
- Waiver agencies submit MI Choice encounter data to CHAMPS electronically. Encounter data for MI Choice services meets CHAMPS requirements (including CHAMPS edits) for processing.
- The CHAMPS system records encounter data detail.
- Waiver agencies use MICIS, COMPASS, or compatible software to maintain an audit trail for funds expended.
- MICIS, COMPASS, or compatible software produces claims detailing provider and participant identification, date of service, specific procedure, and payment data.
- Waiver agencies have written procedures ensuring full payment to providers who furnish MI Choice services according to the authorized PCSP.

9.20 Compliance with Rules and Laws

9.20.A. Civil Rights Compliance

Each waiver agency or direct service provider must not discriminate against any employee or applicant for employment, or against any MI Choice applicant or participant, pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Rights Act (P.A. 453 of 1976), and Section 504 of the Federal Rehabilitation Act of 1973. Each waiver agency or direct service provider must complete an appropriate Federal Department of Health and Human Services form assuring compliance with the Civil Rights Act of 1964.

Each waiver agency or direct service provider must clearly post signs at agency offices and public locations where services are provided in English, and other languages as appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.

9.20.B. Nondiscrimination (Section 1557: Patient Protection and Affordable Care Act)

Section 1557 of the Patient Protection and Affordable Care Act (ACA) applies to the MI Choice program and provides that, except as provided in Title I of the ACA, an individual shall not, on the grounds prohibited under Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or Section 504 of the Federal Rehabilitation Act of 1973, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the ACA. This part applies to health programs or activities administered by recipients of Federal financial assistance from the Department, Title I entities that administer health programs or activities, and Department-administered health programs or activities.

9.20.C. Equal Employment

Each waiver agency and direct service provider must comply with equal employment opportunity principles in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

9.20.D. Drug Free Workplace

MDHHS prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in all waiver agency and direct service provider workplaces. Each waiver agency and direct service provider must operate in compliance with the Drug-Free Workplace Act of 1988.

9.20.E. Americans with Disabilities Act

Each program must operate in compliance with the Americans with Disabilities Act (PL 101-336).

9.20.F. Standard Precautions

Each waiver agency and direct service provider must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. Each waiver agency and direct service provider must establish appropriate standard precautions based upon the potential exposure to blood or infectious materials. Each waiver agency and direct service provider with employees who may experience occupational exposure must also develop an exposure control plan that complies with the Federal regulations implementing the Occupational Safety and Health Act.

9.21 Provider Monitoring Requirements for Waiver Agencies

9.21.A. On-Site Provider Reviews

Waiver agency staff conducts annual on-site monitoring reviews for a minimum of 20% of enrolled providers of recurrent services. This includes adult day health, chore, community living supports, counseling, fiscal intermediary, home delivered meals, transportation, nursing facility transition, nursing services, personal emergency response systems, private duty nursing, in-home and out-of-home respite, supports coordination when not using agency employees, and training. This monitoring plan is to ensure:

Provider compliance to minimum service standards and conditions of participation. This includes compliance to the CMS regulations regarding home and community-based services settings as defined in 42 CFR §441.301(c)(4) and the Home and Community-Based Services Chapter of this Manual.

- Delivery of services according to the authorized MI Choice participant PCSP.
- Provider maintenance of adequate staff recruitment, training plans and staff supervision.
- Provider maintenance of participant case record documentation to support provider claims.

Waiver agency staff evaluates providers of non-recurrent services (durable medical equipment, medical supplies, goods and services, and home modifications) based on frequency and volume of usage at least once every two years to ensure:

- Provider compliance to minimum service standards and conditions of participation
- Delivery of services according to the authorized MI Choice participant PCSP
- Provider maintenance of participant case record documentation to support provider claims

9.21.B. Methodology

The waiver agency assigns one or two staff with primary responsibility for conducting provider reviews using the standardized monitoring tool developed for this purpose (refer to the Directory Appendix). The waiver agency notifies providers in writing at least two weeks in advance of the date scheduled for the review. The waiver agency selects a sample of 10 participant case records or 20% of the provider case records (whichever is greater) to evaluate. The waiver agency staff reviews three months of provider billings to payments for each case record. The waiver agency may choose to monitor more providers as necessary to ensure the quality of services delivered to MI Choice participants. Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-residential surveys provided by MDHHS.

Provider records to review include participant case record documentation, service claims, and reimbursements. The waiver agency compares payment records to MI Choice person-centered service plan authorizations and MI Choice case record documentation.

Waiver agency reviewers evaluate provider records for date of service, time of service delivery, staff providing the service, supervision of staff providing the service, and any discrepancies noted during the review.

The waiver agency reviewers provide written findings of the review and corrective action requirements (as necessary) to the provider within 30 days following completion of the initial review. The waiver agency sends all provider monitoring reports to MDHHS within 30 days of completion of the monitoring process. The written review includes citations of both positive findings and areas needing corrective action.

When results of the initial case record/bill review indicate any irregularities, the reviewer and waiver agency financial staff conducts further review of provider case records covering a specified time. Waiver agency staff may opt to conduct a complete audit of all case records. Following a second review, a written report of the findings is prepared with appropriate corrective actions and sent to the provider and MDHHS within 30 business days following completion of the review. Waiver agency staff schedules a follow-up review within a three to six month timeframe for providers deficient in any part of the review to ensure that the provider initiates and implements corrective action.

Service issues/activities identified for corrective action require the waiver agency to:

- Clearly identify formal findings, state compliance issues, and provide recommendations for corrective action.
- Establish due dates when the provider is scheduled to be in full compliance with the standards and conditions for continued participation.
- Monitor the provider's performance in completing the necessary corrective action.
- Suspend new referrals to the provider agency or transfer participants to another provider when findings warrant immediate action to protect the participant's health or welfare.
- Adjust provider billings on the agency's information system using individual adjustments to date of service or gross adjustment. Deduct overpayments made to a provider from the next warrant issued the provider from the waiver agency. Adjust encounter data submitted to CHAMPS to accurately reflect adjustments made to provider billing.
- Suspend or terminate the providers who demonstrate a failure to correct deficiencies following a second review. The waiver agency can reinstate providers after verifying the provider corrected deficiencies and/or changed procedural practices as required.

Additionally, not included in the sample indicated above, the waiver agency must perform monitoring of 100% of provider-owned/controlled settings and must utilize the Residential and Non-Residential surveys provided by MDHHS. If the setting remains compliant, the waiver agency only needs to maintain the surveys in a file at the waiver agency. The waiver agency must send to MDHHS the completed home and community-based settings survey in the following circumstances:

- The setting is a new setting and has not had a previous survey completed and reviewed by MDHHS and deemed compliant.
- There has been a change in ownership for the setting.

- There have been major changes in how the setting operates their business.

The waiver agency notifies MDHHS immediately of any provider-owned setting that is no longer compliant with the home and community-based services settings regulations as assessed using the Residential Survey for MI Choice Waiver or the Non-Residential Survey for MI Choice Waiver as appropriate. Provider-owned settings include licensed and non-licensed assisted living, AFCs or Homes for the Aged, and adult day health providers. The notification will include the corrective action plan and timeline for implementing the corrective action plan. The waiver agency will be responsible for ensuring the corrective actions have been implemented in a subsequent in-person visit to the setting. The waiver agency will forward the results of the subsequent in-person visit to MDHHS within one to two weeks of completing the visit. The waiver agency will immediately notify MDHHS if the subsequent visit indicates the provider continues to be non-compliant with the ruling and will require MI Choice participants to transition from the setting.

9.21.C. In-Home Participant Visits

To gauge the effectiveness of service delivery accurately, it is necessary to obtain comments regarding service provision from the perspective of the participant and caregiver. From the sample of participant case records reviewed, the waiver agency reviewer selects a minimum of two waiver participants with which they shall conduct home visits. These visits determine participant satisfaction with supports coordination activities and services and verify that providers deliver services as planned.

The in-home visit may correspond to a time when the provider is working in the participant's home. The scheduling of a participant home visit in tandem with the actual service provision allows the waiver agency reviewer to observe the provider at work and the interaction between the worker and the participant. The reviewer interviews the provider to determine their understanding of the tasks they should perform as specified in the PCSP and MI Choice work order. The reviewer also verifies with the participant and caregiver that the provider is delivering services as planned.

The waiver agency reviewer ensures the participant's supports coordinator is aware of pertinent information such as concerns regarding service delivery that the reviewer gathers during the home visit interviews. Supports coordinators follow-up with participant concerns identified during the home visits.

For participants who reside in provider-owned settings (assisted living, AFC, HFA, etc.), waiver agencies complete the additional questions at the end of the participant survey. Any "No" answers provided by the participant (or their authorized representative) require follow-up with the provider to ensure continued compliance to the home and community based services setting requirements.

9.21.D. Coordination with Supports Coordinators

Before or immediately after conducting the on-site provider review, the waiver agency reviewer meets with supports coordinators to discuss utilization of the provider and any problems encountered in using the provider. Additionally, the waiver agency reviews

MI Choice participant case records and other documentation to evaluate the interaction with the provider and determine the frequency of "missed" visits or "no shows" by the provider as related to the plan of service and the MI Choice work order. The review of MI Choice case records assists the waiver agency reviewer to measure provider adherence to the authorized PCSP.

9.21.E. Coordination With Other Waiver Agencies

To the extent feasible and possible, waiver agencies should coordinate monitoring visits to providers that contract with more than one waiver agency. MDHHS encourages waiver agencies to combine efforts to monitor providers under contract with more than one waiver agency. Any time a waiver agency finds rationale to terminate a provider from the provider network, the waiver agency must notify other waiver agencies of the findings and the reason for terminating the contract. This is to mitigate potential harm to other MI Choice participants. Waiver agencies must also notify MDHHS of any contract terminations and the reasons for doing so.

9.21.F. Monitoring Schedule

The waiver agency develops a yearly schedule of provider monitoring reviews to conduct monthly throughout the fiscal year, October 1 to September 30. The schedule is submitted to MDHHS by December 1 each year.

9.22 Provider Enrollment in CHAMPS

Waiver agencies and providers must be compliant with all provider enrollment background and screening requirements as required by the MI Choice program. Any individual or entity that provides applicable MI Choice services and are included in a waiver agency's provider network are required to be screened and enrolled in the Michigan Medicaid Program. Individuals and entities are considered to be included in the provider network when they have a contract with a waiver agency to furnish any of the applicable services, or when they have a contract with a beneficiary enrolled in the MI Choice program to furnish services through a self-determination arrangement.

9.23 Provider Case Records

Waiver agencies assure that agreements with direct service providers contain the following minimum record keeping requirements. The participant case record includes:

- Service work orders or authorizations.
- Assessment, parts or the entire assessment provided by the waiver agency.
- Types of services provided to each participant, i.e., a description of tasks completed by date of service, worker notes describing the tasks completed for each shift, and in-home service logs. Worker time sheets without tasks performed do not meet these criteria.
- Ranges of time that each service is provided (i.e., 10:00 a.m. – 12:00 p.m.); times are subject to change according to participant preferences and waiver agency authorization.
- Date of service delivery.
- Progress notes and supervisory notes.

- Identification of the worker providing each service and that worker's signature.

Additionally, providers are required to maintain the following:

- A worker service record (in-home log) is a daily account of services furnished. The worker providing the service documents tasks accomplished each day. This log may be electronic as long as one is able to indicate all of the tasks performed during a shift. (Telephonic systems that record this information are considered electronic.)
- Service workers maintain a record of services furnished by date of service, description of service provided on each date, and time of service provision each day.
- Service provider agencies may not use worker time sheets as worker service records. Worker time sheets that do not include the tasks performed do not meet the requirement of worker service documentation.
- Absence of a worker service record at a review for any date of service for which the provider makes a claim is equivalent to having no record that the service was rendered and could be subject to Medicaid recovery.
- Service workers must sign each service entry. Electronic systems must include a method to identify the worker providing the information and rendering the service.
- Counseling Records: Providers furnishing MI Choice counseling services maintain ongoing case records for each participant, recording assessed needs, treatment plan, and progress achieved at each counseling session.

SECTION 10 – PROGRAM QUALITY

The process of ensuring the highest quality program involves a continuous cycle of discovery, intervention, and evaluation. MDHHS is resolute about ensuring and improving the quality of services and protections it provides. To ensure that level of service, MDHHS operates a comprehensive quality management system that incorporates reviews of the administrative operations of the waiver agencies, clinical reviews of participant records, home reviews with participants, participant satisfaction surveys, continuous quality management and planning, and timely and effective responses to critical incidents.

Through the course of doing business, MDHHS may identify potential areas of concern with administration of the MI Choice program as specified in the contract between MDHHS and the waiver agency. This includes but is not limited to Clinical and Administrative Quality Assurance Reviews, receipt of complaints from participants or other stakeholders and review of State Fair Hearing Decisions and Orders. MDHHS will investigate all issues to determine their scope. When the scope of an issue is widespread (meaning not isolated to a single participant, supports coordinator, or scenario) or has the potential to impinge upon the rights of participants or applicants, MDHHS will initiate a formal corrective action process. This process begins with identifying the scope of the issue identified and discussing the issue in person with the waiver agency. MDHHS or its designee may require corrective action from the waiver agency. Failure to implement a corrective action plan that addresses the issue identified may lead to implementation of sanctions as identified in the contract between MDHHS and the waiver agencies.

10.1 ADMINISTRATIVE QUALITY ASSURANCE REVIEWS

MDHHS conducts periodic on-site Administrative Quality Assurance Reviews (AQAR) of each waiver agency, ensuring MDHHS reviews each waiver agency at least once every two to three years. MDHHS seeks evidence of compliance to the AQAR standards during the on-site review through examination of waiver agency policies and procedures, provider contracts, financial systems, encounter accuracy, and quality management plans.

Each waiver agency shall adhere to the MDHHS MI Choice Waiver Program Provider Monitoring Plan (known as the Monitoring Plan). The document defines the procedures and standards used by the waiver agency in reviewing providers included in the waiver agency's provider network. It includes the required protocols used to identify provider deficiencies and identifies timelines for remediation. MDHHS will review each waiver agency's process in detail during the AQAR.

MDHHS notifies each waiver agency in writing of deficiencies requiring corrective action and provides a date for the waiver agency to provide a corrective action plan to MDHHS. In the event of a continued deficiency, MDHHS has the authority to take action toward the waiver agency, including the imposition of sanctions as defined in the MI Choice Contract. MDHHS has the option to suspend or terminate the Contract of any waiver agency that fails to correct stated deficiencies identified on a second review.

10.2 QUALITY MANAGEMENT PLANS

Each waiver agency must have a written quality management plan that meets requirements specified in the MDHHS Quality Management Plan. The Quality Management Plan addresses quality assurance and improvement using measurable goals and quality performance indicators.

MDHHS reviews quality management plans annually. Waiver agencies are required to submit an annual report to MDHHS highlighting their quality management plan activities and improvements. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

Waiver agencies have a written local quality management plan for its SC operations that includes supervisory oversight procedures, clinical review of SC functions, methods used to identify programmatic deficiencies, and methods used to provide feedback to effect improvements. These plans must also include CMS and MDHHS requirements as specified in 42 CFR §438.608 and Attachment C of the MI Choice Contract. MDHHS annually reviews the internal SC quality management plan, Quality Management Plan (QMP) outcomes, and accomplishments as cited in annual reports.

10.3 Clinical Quality Assurance Reviews

MDHHS contracts with an External Quality Assurance Review agency to conduct an annual Clinical Quality Assurance Review (CQAR) of each waiver agency. The review is to determine whether the authorized services in the person-centered service plan are sufficient to protect the health and welfare of the participant and to determine whether the waiver agency is abiding by the laws, rules, and regulations that govern the MI Choice program. The primary means of gathering information for the CQAR include reviewing case records and interviewing waiver agencies and participants.

Randomly selected records are reviewed. Samples are derived using federally-approved sampling techniques with a minimum of 10 records reviewed at each agency. In addition, a minimum of five home visits are conducted to verify information in the records. The review is conducted by a team of trained and qualified reviewers.

10.4 Critical Incident Response and Reporting

MI Choice is required to track and to report certain events that might indicate exceptional risk to the participant. Not only are these requirements defined in regulation, but also in law. A "critical incident" is any actual, alleged, or suspected event or situation that occurs as a result of abuse, neglect, exploitation, or any event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant.

10.4.A. Types of Critical Incidents and Serious Events

The following are specific critical incidents or serious events that must be reported to MDHHS:

- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Neglect
- Physical abuse
- Provider no-shows, particularly when the participant is bed-bound all day or there is a critical need for the service to be provided as indicated by a 1A, 1B, or 1C service need level and no successful backup plan
- Sexual abuse

- Theft – of anything
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Suspicious or unexplained death that the waiver agency, or other entity, reports to law enforcement and that is related to providing services, supports, or care
- Medication errors resulting in emergency medical treatment or hospitalization
- Injuries requiring medical treatment
- Restraints, seclusion or restrictive interventions
- Hospitalization or emergency department visits within 30 days of previous hospitalization due to neglect or abuse
- Other – other event that creates a significant or potential risk of substantial or serious harm to the physical or mental health, safety or well-being of a waiver participant not already listed (fire, drive by shooting, car accident, etc.).

10.4.B. Critical Incident Response

MI Choice waiver agencies have the initial responsibility for identifying, investigating, evaluating and responding to critical incidents that occur with participants as listed above. All suspected incidents of abuse, neglect and exploitation require reporting to MDHHS Adult Protective Services (MDHHS-APS) for investigation and follow-up. Agencies shall begin investigating and evaluating critical incidents within two business days of the date that it was noted that an incident occurred. Unexplained death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.

Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with MDHHS-APS to determine the result of the reported incident and the steps to be taken if the results are unsatisfactory. All reports to MDHHS-APS must be maintained in the participant's case record.

10.4.C. Critical Incident Reporting

Waiver agencies are responsible for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies. MDHHS must receive notification from waiver agencies of suspicious deaths within two business days. Waiver agencies submit critical incident reports to the MDHHS, MSA, Home and Community Based Services Section as they occur using the Critical Incident Management System.

Waiver agencies must require contracted providers to report unexpected deaths to the waiver agency within two business days of the unexpected death. For all other Critical Incidents, contracted providers must report to the waiver agency within 30 calendar days

of the Critical Incident. Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident.

Once the waiver agency is notified of the Critical Incident, MDHHS requires waiver agencies to enter, report, and provide updates to critical incidents within two business days of the waiver agency becoming aware of the incident.

Waiver agencies report to MDHHS all critical incidents including:

- A description of each incident;
- Investigations and strategies implemented to reduce, ameliorate, and prevent future incidents from occurring; and
- Follow-up activities conducted through the resolution of each incident. Critical Incidents should be resolved within two months unless there are extenuating circumstances, or an investigation is ongoing. If the Critical Incident is not resolved within two months, the notes should be updated frequently until the Critical Incident is resolved.

SECTION 11 – GRIEVANCES AND APPEALS

Waiver agencies have written appeal processes consistent with MDHHS policy and 42 CFR §438. The participant has the right to request an appeal for any action, failure to act, or undue delay by the waiver agency. The participant initiates an appeal with the MDHHS Field Office when the participant disagrees with a financial eligibility determination. The participant initiates an appeal with the waiver agency when the participant disagrees with any other decision or action made by the program other than LOCD. The participant initiates an appeal with MDHHS Michigan Office of Administrative Hearings and Rules (MOAHR) when the participant disagrees with an action made related to the LOCD. Waiver agency staff may assist participants with filing the appropriate appeal documents.

MDHHS has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found in federal law.

All Medicaid applicants and recipients have the right to a fair hearing. Waiver agencies, as a Medicaid managed care provider, have certain responsibilities related to the rights of persons applying for or receiving MI Choice services. This includes providing the applicant or participant with appropriate notice of their right to request an appeal when the waiver agency takes an adverse action against them, or a grievance when they are dissatisfied with the quality of services received. For applicants and participants of MI Choice, an adverse action occurs when, but is not limited to, situations where the waiver agency does any of the following:

- Suspends or terminates participation in MI Choice;
- Denies an applicant's request for participation in MI Choice;
- Reduces, suspends, terminates, or adjusts MI Choice services currently in place;
- Denies an applicant's or participant's request for MI Choice services that are not currently provided; or
- Denies a participant's request for additional amounts of currently provided services.

Attachment C of the MI Choice Contract specifies requirements for the waiver agency's Grievance and Appeal system, including time frames for making decisions and the individual's right to a Medicaid Fair Hearing after exhausting the waiver agency's process.

11.1 PARTICIPANT GRIEVANCES

Waiver agencies must establish their own internal grievance process. Participants may file a grievance orally or in writing when they are dissatisfied with the quality of services received. A grievance may be submitted to the waiver agency at any time. Waiver agencies must address grievances according to the time frames and requirements set in federal law and in the MI Choice Contract.

11.2 PARTICIPANT INTERNAL APPEALS

Waiver agencies must establish their own internal appeal process for participants to file an appeal with the agency. The internal appeal process must conform to requirements and time frames set by federal law and the MI Choice Contract. The internal appeal process applies only to MI Choice enrolled participants and in the following situations:

- The waiver agency is denying a requested service that is not already in place,
- The waiver agency is terminating, suspending or reducing a service that is already in place,
- The waiver agency is taking action or making an adverse determination based on suspicion of fraud, or
- In areas with only one waiver agency, the denial of a participant's request to exercise their right to obtain services outside the network.

Waiver agencies must send the participant an Adverse Benefit Determination notice when making any of the adverse decisions listed above. The Adverse Benefit Determination notice must meet the requirements specified in federal law and the MI Choice Contract. CMS requires managed care providers to send an Adverse Benefit Determination notice to MI Choice participants when the waiver agency makes decisions regarding their access to MI Choice services. Each Adverse Benefit Determination sent to the participant must be in writing and meet the language needs of the individual so the recipient understands the content (i.e., the format meets the needs of those with limited English proficiency and/or limited reading proficiency). Participants have 60 calendar days from the date of the Adverse Benefit Determination to request an internal appeal.

If the internal appeal decision upholds the action described in the Adverse Benefit Determination and the participant remains unsatisfied, the participant or legal representative may request a State Fair Hearing.

When an applicant or participant does not meet the LOCD, waiver agencies will bypass the Internal Appeal process and provide the individual with the necessary State Fair Hearing request forms pertaining to LOCD. Waiver agencies must use the version of the State Fair Hearing request form (DCH-0092-MOAHR) with the "EDW-LOCD" code entered in the "State Program or Service being provided to this client" field. Waiver agencies must also utilize the Adequate Action Notices on the LOCD website instead of the Notice of Adverse Benefit Determination. Applicants or participants must be made aware that they have the option to request a Secondary Review as identified on the hearing notice.

11.3 State Fair Hearing

Applicants for MI Choice may request a State Fair Hearing when the waiver agency makes an adverse determination. MI Choice participants may request a State Fair Hearing when the waiver agency issues an internal appeal decision that upholds the action described in the Adverse Benefit Determination or when the waiver agency does not adhere to the time frames required for making a decision in an internal appeal.

Waiver agencies must provide adequate or advance notice to the applicant or participant that conforms to the requirements and time frames specified in federal law and the MI Choice Contract.

11.4 Provider and Waiver Agency Appeals

Medicaid providers, including waiver agencies, are afforded appeal rights under the Michigan Social Welfare Act (Public Act 280 of 1939, as amended) and the Michigan Administrative Code. Adverse actions that may be appealed by providers include, but are not limited to, the suspension or termination of participation in the Medicaid program or a reduction, suspension, or adjustment of provider payments.

Information regarding the MDHHS appeal process is available in the General Information for Providers chapter and on the MDHHS website. (Refer to the Directory Appendix for website information.)

MI Health Link

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SECTION 1 – GENERAL INFORMATION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.

1.1 ELECTRONIC VISIT VERIFICATION

The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. PCS provided through MI Health Link must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information.

SECTION 2 – ELIGIBILITY AND SERVICE AREAS

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

Region	Counties in the Region
1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
7	Wayne
9	Macomb

Excluded populations:

- Individuals under age 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56
- Individuals not living in one of the four demonstration regions
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
- Individuals without full Medicaid coverage (they have spenddowns or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial Health Maintenance Organization (HMO) coverage
- Individuals with elected hospice services prior to MI Health Link program enrollment
- Individuals with Medicaid who reside in a State Veterans' Home

SECTION 3 – ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways: 1) voluntary enrollment, and 2) passive enrollment. For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the state for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Eligible individuals who do not voluntarily enroll in the program will receive a notification letter at least 60 days prior to the enrollment effective date informing them they will be passively enrolled. Eligible individuals will have a period of 60 days to opt out of the program if they choose to do so prior to the enrollment effective date. Individuals may opt out by calling the entities as indicated in the notification letter. Individuals who do not opt out of the program prior to the effective date will be passively enrolled and an ICO will be assigned to them. Prior to the enrollment effective date, and at any time thereafter, individuals will have the opportunity to select a different ICO than the one assigned to them if there is another ICO option in the region.

After enrollment, individuals are issued an identification (ID) card that is specific to the MI Health Link program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the ICO responsible for coverage along with the MI Health Link logo. Individuals will be enrolled in the benefit plan called ICO-MC, which is a benefit plan specific to the MI Health Link program. (Refer to the Beneficiary Eligibility Chapter for additional information.)

Individuals who are enrolled in the MI Choice waiver or the Program of All-Inclusive Care for the Elderly (PACE) are not passively enrolled into MI Health Link. These individuals may enroll in MI Health Link voluntarily, but must disenroll from MI Choice or PACE before the MI Health Link enrollment is effective. MDHHS will assist in this process to ensure a smooth transition between programs. Individuals who are enrolled in MI Choice or PACE and wish to enroll in MI Health Link must call the enrollment broker to start the enrollment process. The enrollment broker will send a message to MDHHS notifying MDHHS that the individual has chosen to enroll in MI Health Link. MDHHS staff will contact the appropriate MI Choice waiver agency or PACE organization to obtain current information and assessments for the individual. MDHHS will review the information received to determine if the individual's needs can be met through MI Health Link. MDHHS will contact the individual to discuss whether their needs can be met in MI Health Link. If the individual still chooses to join MI Health Link at that time, MDHHS will initiate the formal enrollment in the program and will notify the ICO accordingly.

Individuals may choose to disenroll from MI Health Link at any time. Disenrollment is effective on the first day of the following month.

SECTION 4 – PROGRAM ENROLLMENT TYPES

For individuals enrolled with an ICO and who are residing in a NF or County Medical Care Facility (CMCF), the ICO-NFAC or ICO-CMCF PET codes will be updated in CHAMPS when the NF or CMCF completes the Nursing Facility Admission in CHAMPS. The ICO-NFAC or ICO-CMCF PET code will be removed upon the facility completing the NF discharge information in CHAMPS when the individual is discharged from the facility.

Similarly, when a MI Health Link enrollee elects hospice services, the ICO-HOSC, ICO-HOSW, ICO-HOSN, ICO-HOSR or ICO-HOSH PET codes will be updated in CHAMPS when the hospice provider completes the Hospice Admission in CHAMPS. When the individual expires or otherwise is discharged from hospice services, the hospice provider must complete the Hospice Discharge in CHAMPS, which then removes the hospice-related PET codes.

When the MI Health Link enrollee receives hospice services while residing in a NF or CMCF, the hospice provider must indicate the facility of residence on the Hospice Admission in CHAMPS so the ICO can receive the appropriate capitation rate.

SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services and hearing aid coverage
- Dental services
  - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.
- Long Term Supports and Services (LTSS)
  - Nursing facility services
  - State Plan personal care services
  - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.
  - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD
- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.

5.1.A. Provider Qualifications

A criminal history screen must be conducted for all personal care providers. In addition, the provider must meet the following qualifications:

- Be 18 years of age or older;
- Be able to follow instructions, personal care procedures, perform the services required and handle emergencies;
- Be physically able to perform the needed services;
- Be knowledgeable about when to seek assistance from appropriate sources in the event of an emergency;
- Be dependable and able to meet job demands; and
- Be willing to participate in available training programs if necessary.

5.1.B. Assessment Requirements

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The in-person, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be in-person.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

Independent	The individual performs the activity with no human assistance.
Verbal assistance	The individual performs the activity with verbal assistance such as reminding, guiding or encouraging.
Minimal human assistance	The individual performs the activity with some direct physical assistance and/or assistance technology.
Moderate human assistance	The individual performs the activity with a great deal of human assistance and/or assistive technology.
Dependent	The individual does not perform the activity even with human assistance and/or assistance technology.

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater. In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible

for IADL services. Once an individual is determined eligible for personal care services, their authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

5.1.C. Personal Care Services and the MI Health Link HCBS Waiver

If an individual ranks at a level 1 or 2, they will not be eligible for State Plan Personal Care Services through MI Health Link. If an individual ranks at a level 2, they may be eligible for ADL assistance through the MI Health Link HCBS waiver Expanded Community Living Supports (ECLS) benefit if the individual requires prompting, cueing, guiding, teaching, observing, or reminding to complete ADLs. Through the MI Health Link HCBS waiver, an individual may receive IADL assistance if they receive prompting, cueing, guiding, etc. to complete ADLs.

ECLS may be provided in addition to State Plan Personal Care Services if the individual requires hands-on assistance with some ADLs, as covered under Personal Care Services, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs and IADLs independently to ensure safety, health, and welfare of the individual.

5.1.D. Reasonable Time and Task

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

5.1.E. Complex Care Needs

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed for individuals whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or individual may be required in order to perform.

- Eating and feeding
- Catheters or legs bags
- Colostomy care
- Bowel program
- Suctioning
- Specialized skin care
- Range of motion exercises
- Peritoneal dialysis

- Wound care
- Respiratory treatment
- Ventilators
- Injections

The ICO Care Coordinator will allocate time for each task assessed a rank of 3 or greater based on interviews with the individual and provider, observation of the individual's abilities, and use of the RTS as a guide. When hours exceed the RTS, a rationale must be provided and maintained in the individual's record.

An assessment of need at a ranking of 3 or greater does not automatically guarantee the maximum allotted time allowed by the RTS. The ICO Care Coordinator must assess each task according to the actual time required for its completion.

5.1.F. Reimbursement and Rates

After enrollment and according to the requirements of the three-way contract, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with individual approval. An ICO should use the Medicaid Home Help Payment Schedule to continue paying providers as scheduled. (Refer to the Directory Appendix for additional information.) An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule, which should be defined in the contract between the ICO and the personal care provider. The ICO must publish a pay cycle and must pay these claims on the next available pay cycle date.

Furthermore, an ICO should use the Individual and Agency County Rates to determine payment rates for the transition period until the ICO and personal care provider agree upon a rate that is defined in the ICO and personal care provider contract. (Refer to the Directory Appendix for additional information.)

After the transition period, payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs, except for administering medications) and responsible relatives able and available to assist.

If the individual does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) must be **prorated by one half** in shared living arrangements where other adults reside in the home as personal care services are only for the benefit of the individual. This does not include situations where others live in

adjoined apartments, flats or in a separate home on shared property and there is no shared common living area. In shared living arrangements where it can be clearly documented that IADLs for the enrolled individual are completed separately from others in the home, hours for IADLs do not need to be prorated.

5.1.G. Responsible Relatives and Guardians

Adult children (18 years of age or older) may provide personal care services to a parent. An individual's spouse cannot be paid to provide personal care services to the individual as they are considered responsible relatives. Couples who are separated must provide verification that they are no longer residing in the same home. Verification may include a driver's license, rent receipt or utility bill reflecting their separate mailing address. A spouse who is legally separated from a spouse cannot be paid to provide personal care services. ADLs may be approved when an individual's spouse is unavailable or unable to provide these services. "Unavailable" means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. "Unable" means the responsible person has disabilities of their own which prevent them from providing care.

Shopping, laundry, or light housecleaning shall not be approved when a responsible relative of the individual resides in the home unless they are unavailable or unable to provide these services. These findings must be documented.

5.1.H. Individuals in Adult Foster Care Facilities and Home for the Aged

For individuals in adult foster care facilities or home for the aged, a flat monthly supplement rate is established annually by the state legislature for those Medicaid beneficiaries who, according to a standardized assessment, have a documented need for personal care services. The supplement rate is included in the ICO rates, and the ICOs must pay this rate to adult foster care homes and homes for the aged providers for individuals enrolled in MI Health Link. ICOs and Adult Foster Care facilities and Homes for the Aged must use the billing invoice provided by MDHHS.

5.2 Supplemental Services

MI Health Link supplemental services are available for any individuals who live in the community, wish to move from a nursing facility to the community, do not meet LOCD and are not enrolled in the MI Health Link HCBS waiver. The four supplemental services are Adaptive Medical Equipment and Supplies, Community Transition Services, Personal Emergency Response System, and Respite.

5.2.A. Adaptive Medical Equipment and Supplies

This service includes devices, controls, or appliances specified in the IICSP that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State

Plan and Medicare that are necessary to address individual functional limitations. This will also cover the costs of equipment maintenance. The coverage includes training the individual and/or caregivers in the operation and/or maintenance of the equipment and the use of a supply when initially purchased. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not approved by the United States Food and Drug Administration (FDA).

All items shall meet applicable standards of manufacture, design, and installation. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment (DME) provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter. The ICO may obtain some items directly from a retail store that offers the item to the general public. When utilizing retail stores, the ICO must ensure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific individual who received the purchased item. Items must be of direct medical or remedial benefit to the individual, and this benefit must be documented in the individual's record.

It must be documented on the IICSP or Care Bridge Record that the item is the most cost-effective alternative to meeting the individual's needs. There must be documentation on the IICSP or Care Bridge record that the best value in warranty coverage was obtained at the time of purchase. Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with Michigan Scope of Practice laws). Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the individual's physician.

5.2.B. Community Transition Services

Community Transition Services (CTS) include non-reoccurring expenses for individuals transitioning from a nursing facility to another residence where the individual is responsible for their own living arrangement. Person-centered planning must be used throughout the entire community transition process. The ICO shall begin CTS no more than six months before the expected discharge from the nursing facility. Allowable transition costs include the following:

- Housing or security deposit: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television service and internet are excluded).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
- Cleaning: A one-time cleaning expense to ensure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of an individual to a community setting.

- Other services deemed necessary and documented within the individual's plan of service to accomplish the transition into a community setting.

Ongoing monthly rental or mortgage expense, ongoing utility charges, or items that are intended for purely diversional or recreational purposes are excluded under this service.

5.2.C. Personal Emergency Response System

A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once the "help" button is activated. The PERS provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The individual must reside in an area where cellular or mobile coverage is reliable. When the individual uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The PERS provider must ensure at least monthly testing of each PERS unit to maintain proper functioning.

PERS does not cover monthly telephone charges associated with phone service. This service is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The ICO may authorize PERS units for individuals who do not live alone if both the waiver individual and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

The Federal Communication Commission (FCC) must approve the equipment used for the response system. The equipment must meet UL® safety standards 1637 specifications for Home Health Signaling Equipment.

The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. The response center must maintain the monitoring capacity to respond to all incoming emergency signals. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put on a first call, first serve basis. The provider will furnish each responder with written instructions and provide training, as appropriate.

5.2.D. Respite

Respite services may be provided at the individual's home, in the home of another person, or at another setting outside the individual's home. Respite service criteria are different depending on the setting. Respite services are limited to a total of 14 overnight stays per 365 days regardless of the setting. The ICO may provide more respite services as an optional benefit. For individuals receiving respite services through the PIHP, they

must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.

5.2.D.1. Respite Provided at the Individual's Home or in the Home of Another Person

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in the payment for respite services.

5.2.D.2. Respite Provided Outside the Home

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in Michigan Compiled Law (MCL) 400.701ff, which includes adult foster care homes and homes for the aged. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.

Respite services include:

- Attendant care (individual is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.

- Basic care (individual may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

Out-of-home respite may be scheduled for several days in a row depending upon the needs of the individual and the individual's caregivers.

5.3 MI Health Link HCBS Waiver Services

These services are intended for individuals who meet all of the following criteria:

- are enrolled in the MI Health Link program,
- meet nursing facility level of care as determined by the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool,
- demonstrate a need for one or more of the services listed below, which must be identified in the IICSP.

Individuals must receive at least one waiver service each month to remain on the waiver. The ICO and direct service providers must adhere to the service definition and operating standards to be eligible to receive payment of waiver expenses.

5.3.A. Adaptive Medical Equipment and Supplies

For the definition of the Adaptive Medical Equipment and Supplies service, refer to the Supplemental Services section, Adaptive Medical Equipment and Supplies.

5.3.B. Adult Day Program

Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the IICSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the individual's residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the ICO will pay for the transportation to and from the Adult Day Program center separately.

Individuals cannot receive personal care services or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services, but cannot be provided at the same time unless the specific

component of the service includes laundry, housecleaning, etc., that does not require the individual to be present.

Adult Day Program may be authorized only if the individual meets at least one of the following criteria:

- Requires regular supervision to live in their own home or the home of a relative.
- If they have a caregiver, the individual must require a substitute caregiver while their regular caregiver is unavailable.
- Has difficulty or is unable to perform ADLs without assistance.
- Capable of leaving the residence with assistance to receive services.
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization.

A referral from an ICO for a waiver individual shall replace any screening or assessment activities performed for other Adult Day Program individuals at the setting. The direct Adult Day Program service provider shall accept copies of the ICO's assessments and IICSP to eliminate duplicate assessment and service planning activities.

Each program shall provide directly, or coordinate with the ICO to arrange for the provision of the following services:

- Transportation
- Personal Care
- Nutrition: one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Individuals in attendance from eight to fourteen hours per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration individual choice, health, religious and ethnic diet preferences.
- Recreation: consisting of planned activities suited to the needs of the individual and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction.

If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. The ICO shall provide care coordination.

Each program shall keep all individuals' files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.

Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person

for every ten participants. The provider may only provide health support services under the supervision of a Registered Nurse (RN). If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

Each program shall establish written procedures (reviewed and approved by a consulting pharmacist, physician, or RN) that govern the assistance given by staff to individuals taking their own medications while participating in the program. The policies and procedures must minimally address:

- Written consent from the individual or individual's representative to assist with medications.
- Verifications of the individual's medication regimen, including prescriptions and dosages.
- The training and authority of staff to assist individuals with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
- Procedures for medication set up.
- Secure storage of individuals' medications. Medications must be returned to the individual.
- Instructions for entering medication information in individual files, including times and frequency of assistance.

Program staff shall have basic first-aid training and any other training as required by MDHHS and the ICO.

If the provider operates its own vehicles for transporting individuals to and from the program site, the provider shall meet the following transportation minimum standards:

- The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
- All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
- All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
- Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

The provider shall maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each Adult Day Program center must have the following furnishings:

- At least one straight back or sturdy folding chair for each individual and staff person.
- Lounge chairs and/or day beds as needed for naps and rest periods.
- Storage space for individuals' personal belongings.

- Tables for both ambulatory and non-ambulatory individuals.
- A telephone accessible to all individuals.
- Special equipment as needed to assist persons with disabilities.

Each provider shall post emergency procedures (fire, severe weather, etc.) in each room of the program site. Practice drills of emergency procedures must occur once every six months. The program shall maintain a record of all practice drills.

Each Adult Day Program center must document that it is in compliance with:

- Barrier-free design specification of Michigan and local building codes.
- Fire safety standards.
- Applicable Michigan and local public health codes.

Adult Day Program settings must be compliant with the HCBS Final Rule as indicated in the Home and Community-Based Residential and Non-Residential Settings subsection.

5.3.C. Assistive Technology

The Assistive Technology service includes technology items used to increase, maintain, or improve an individual's functioning and promote independence. The service may include assisting the individual in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the individual's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the individual and specified under the IICSP. Some examples of assistive technology include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener and specialized alarm or intercom.

Cost limits for this service are as follows:

- $15,000 maximum for van lifts, including tie-downs, for the duration of the 5-year waiver period
- $5,000 yearly (waiver year) maximum for all other assistive technology devices

Items must be of direct medical or physical benefit to the individual. Where feasible, the ICO and/or direct service provider must seek confirmation of the need for the item from the individual's physician. It must be documented in the IICSP that the item is the most cost-effective alternative to meeting the individual's needs. Items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.

Modifications will only be made to vehicles with proper insurance coverage, with the exception of new vehicles coming directly from an automotive factory to the entity performing the modification.

Direct service providers must enroll in Medicare and Medicaid as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the ICO and/or the three-way contract. Contracted/subcontracted providers must have appropriate state licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

Items like cell phones, internet service, and full-home wiring systems are excluded from this benefit. This service also does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.

5.3.D. Chore Services

Chore Services include those duties needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home, and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver individuals.

Chore services are covered only in cases when neither the individual nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the IICSP. The ICO must deem the chosen provider capable of performing the required tasks. Pest control suppliers must be properly licensed.

5.3.E. Community Transition Services

For the definition of Community Transition Services (CTS), refer to Community Transition Services in the Supplemental Services subsection.

For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning individual requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed

modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.

5.3.F. Environmental Modifications

The Environmental Modifications service covers physical adaptations to the home, required in the individual's IICSP, that are necessary to ensure the health and welfare of the individual or that enable the individual to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual. Complex kitchen and bathroom modifications may be completed if medically necessary for the individual. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence. A ramp or lift will be covered for only one exterior door or other entrance.

The modification/adaptation must be for a primary residence, but may include additional residences subject to prior authorization by the ICO. Examples of additional residences might be a family member's cottage or the individual's second home or cottage so the individual can go there to be with family.

The modification/adaptation must be the most cost-effective and reasonable alternative. Any modifications/adaptations shall only be used to modify existing spaces or structures. The existing structure must have the capability to accept and support the proposed changes. Repairs, modifications, or adaptations shall not be performed on a condemned structure. Modifications must comply with local building codes. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.

Environmental modifications/adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an individual's home.

The ICO may use MI Health Link funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.

Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the individual, and the ICO must specify that the ICO and individual are not responsible for any costs to restore the property to the original condition.

Excluded from this service are those adaptations or improvements to the home that:

- Are of general utility.
- Are considered to be standard housing obligations of the individual or homeowner.
- Are not of direct medical or remedial benefit to the individual. For example, kitchen modifications must be required for the individual to prepare their own meals.
- Modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.
- Are used for upgrades to the home or for additions to homes (adding square footage, etc.).
- Are improvements exclusively required to meet local building codes and not directly related to an individual's medical or physical condition.

Some examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The ICO shall not cover general construction costs in a new home or additions to a home purchased after the individual is enrolled in the waiver. If an individual or the individual's family purchases or builds a home while receiving waiver services, it is the individual's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the individual has mobility limitations. However, MI Health Link funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening of doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the ICO may fund the difference between the standard fixture and the modification required to accommodate the individual's need.

Contracted providers (such as licensed building contractors) must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3). Verification of certification, licensure, or other provider qualifications must be done prior to execution of the contract related to the modification project to be done.

5.3.G. Expanded Community Living Supports

To receive ECLS, individuals MUST need prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete ADLs. ECLS does not include hands on assistance for ADLs unless something occurs incidental to this service. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.

ECLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in the following activities:
  - Meal preparation
  - Laundry
  - Routine, seasonal, and heavy household care and maintenance
  - ADLs such as bathing, eating, dressing, and personal hygiene
  - Shopping for food and other necessities of daily living
- Assistance, support, and/or guidance with activities such as:
  - Money management
  - Non-medical care (not requiring nursing or physician intervention)
  - Social participation, relationship maintenance, and building community connections to reduce personal isolation
  - Transportation (excluding to and from medical appointments) from the individual's residence to community activities, among community activities, and from the community activities back to the individual's residence
  - Participation in regular community activities incidental to meeting the individual's community living preferences
  - Attendance at medical appointments
  - Acquiring or procuring goods and services necessary for home and community living
- Reminding, cueing, observing, and/or monitoring of medication administration.
- Staff assistance with preserving the health and safety of the individual in order that they may reside and be supported in the most integrated independent community setting.
- Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
- Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the individual as identified in the individual's IICSP.
- Observing and reporting to the ICO Care Coordinator any changes in the individual's condition and the home environment.

If the individual has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, ECLS services that only require verbal cueing may be provided via a HIPAA compliant virtual method (audio and video only; cannot be only audio) in lieu of in-person during the quarantine or isolation period only. Approval of remote support must be reflected on the individual's integrated care and support plan.

Individual providers chosen by the individual must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation related to this service, the provider must possess a valid Michigan driver's license.
- Providers of ECLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained on the individual's specific needs as identified in the IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.
- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.
- Must be deemed capable of performing the required tasks by ICO.

Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal history review.
- A RN licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
- The ICO and/or provider agency must train each worker to properly perform each task required for each individual the worker serves before delivering the service to that individual. The supervisor must ensure that each worker can competently and confidently perform every task assigned for each individual served. MDHHS strongly recommends each worker delivering ECLS services complete a certified nursing assistance training course.
- ECLS providers may prompt, cue, or supervise the individual to perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each individual who requires such care. The supervising RN must ensure each worker's confidence and competence in the performance of each task required.
- ECLS service providers must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting,

and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.

- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.

When the ECLS services include transportation, the following standards apply:

- The ICO may not use MI Health Link funds to purchase or lease vehicles for providing transportation services to waiver individuals.
- The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MI Health Link funds. The provider must cover all vehicles used with liability insurance.
- All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
- The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Health Link funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
- Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

If the individual has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, transportation on behalf of the individual during the quarantine or isolation period to allow others to obtain items required for the individual is acceptable. Plans may use this service to authorize MI Health Link HCBS funds to reimburse individuals (ECLS providers) to run errands for enrollees when the enrollee does not accompany the driver of the vehicle during only an applicable quarantine or isolation period. The purpose of expanding the ECLS service is for the enrollee to gain access to the community as needed during these temporary periods.

Each direct service provider who chooses to allow staff to assist individuals with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall include, at a minimum:

- The provider staff authorized to assist individuals with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the individual takes and its impact upon the individual.
- Verification of prescription medications and their dosages. The individual shall maintain all medications in their original, labeled containers.
- Instructions for entering medication information in individual files.

- A clear statement of the individual's and their legal representative's responsibility regarding medications taken by the individual and the provision for informing the individual and their legal representative of the provider's procedures and responsibilities regarding assisted self-administration of medications.

ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:

- A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
- A provider shall ensure that medication use conforms to federal standards and the standards of the medical community.
- A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
- A provider shall review the administration of a psychotropic medication periodically as set forth in the individual's IICSP and based upon the individual's clinical status.
- If an individual cannot administer their own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
- A provider shall record the administration of all medication in the individual's record. The ICO may do this electronically or via paper format, but the records must be readily available if requested by MDHHS.
- A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the individual's record.

ECLS cannot be provided in circumstances where they would be a duplication of services available through MI Health Link. The distinction must be apparent by unique hours and units in the approved IICSP.

ECLS may be furnished outside the individual's home.

The individual oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the IICSP. When transportation incidental to the provision of ECLS is included, the ICO shall not also authorize transportation as a separate waiver service for the individual.

Members of an individual's family may provide ECLS to the individual. However, the ICO shall not directly authorize funds to pay for services furnished to an individual by that person's spouse or legal guardian or other financially responsible person. Family members who provide this service must meet the same standards as providers who are unrelated to the individual. Roommates or other individuals who live with the individual may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e., meal preparation, laundry, housecleaning, etc.). Paid ECLS services are only for the benefit of the individual receiving the services.

In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need not be pro-rated. Providers must be trained to perform each required task prior to service delivery. The supervisor must ensure the provider can competently and confidently perform each assigned task.

With the assistance of the individual and/or individual's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each individual, pursuant to each visit for emergencies and provider no-shows or late arrivals.

ECLS does not include the cost associated with room and board. ECLS also excludes nursing and skilled therapy services.

ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting. Documentation in the individual's record must clearly identify the individual's need for additional supports and services not covered by licensure. The IICSP must clearly identify the portion of the individual's supports and services covered by ECLS. The setting must comply with the requirements of the Home and Community-Based Services (HCBS) Final Rule as described in the Home and Community-Based Residential and Non-Residential Settings subsection.

5.3.H. Fiscal Intermediary

Fiscal Intermediary (FI) services assist the individual to live independently in the community while controlling their individual budget and choosing the staff to work with them. The FI helps the individual to manage and distribute funds contained in the individual budget. The individual uses funds to purchase home and community based services authorized in the IICSP. FI services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring individual-directed budget expenditures and identify potential over and under expenditures; ensuring compliance with documentation requirements related to management of public funds. The FI helps the individual manage and distribute funds contained in the individual budget. The FI also assists with training the individual and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

FI services are available only to individuals participating in arrangements that support self-determination. Additionally, FI services may not be provided by the individual's family, guardian, or providers of other services for the same individual. The ICO and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements provided by MDHHS. FI services through the MI Health Link HCBS waiver must only be used for MI Health Link HCBS services as identified in the CMS-approved 1915(c) waiver application.

Each FI must:

- Be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.
- Demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
- Demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
- Provide four basic areas of performance:
  - Function as the employer agency for individuals directly employing workers to ensure compliance with payroll tax and insurance requirements;
  - Ensure compliance with requirements related to management of public funds, the direct employment of workers by individuals, and contracting for other authorized supports and services;
  - Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each individual and ICO; and
  - Offer supportive services to enable individuals to self-determine and direct the supports and services they need.

5.3.I. Home Delivered Meals

This service is the provision of one to two nutritious meals per day to individuals who are unable to care for their nutritional needs. This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law. Meal options must meet individual preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences. ICOs must follow the minimum operating standards for this service as well as ensure provider qualifications as provided by MDHHS are met prior to delivery of services and annually thereafter.

Each ICO must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:

- The individual must be unable to obtain food or prepare complete meals.
- The individual does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
- The individual does not have a paid caregiver that is able and willing to prepare meals for the individual.
- The provider can appropriately meet the individual's special dietary needs, and the meals available would not jeopardize the health of the individual.
- The individual must agree to be home when meals are delivered. For any unavoidable absence, the provider or ICO must be contacted. If the ICO is contacted, they must contact the provider.

If the individual has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, home delivered meals may be left at the enrollee's door in lieu of in-person during the quarantine or isolation period only. Approval of door drop-off must be reflected on the individual's integrated care and support plan.

Meal Delivery Kit providers are an acceptable provider of Home Delivered Meals in addition to traditional Home Delivered Meal Agencies.

5.3.J. Non-Medical Transportation

This service is offered to enable individuals to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP). Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. Need for this service and details as to whom and how it will be provided should be discussed in the person-centered planning meeting and documented in the IICSP.

Direct service providers shall be a centrally organized transportation company or agency. Transportation may be provided by any of the following methods:

- Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
  - Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the individual.
  - Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.
- Public Transit: Characterized by partial or full payment of the cost for an individual to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.
- Volunteer: Characterized by reimbursement of out-of-pocket expenses for individuals who transport individuals in their private vehicles. The provider may include a passenger assistance component.
- Ambu-cab: Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance. MI Health Link funds may not be used to purchase or lease vehicles for providing transportation services to waiver individuals. All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with

medical emergencies, unless expressly prohibited by a labor contract or insurance policy. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

MI Health Link funds shall not be used to reimburse caregivers (paid or informal) to run errands for individuals when the individual does not accompany the driver of the vehicle.

5.3.K. Personal Emergency Response System

For the definition of the Personal Emergency Response System (PERS) definition, refer to Personal Emergency Response System in the Supplemental Services subsection.

5.3.L. Preventive Nursing Services

Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an individual who generally requires nursing services for the management of a chronic illness or physical disorder in the individual's home and are provided by a RN or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for individuals who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the individual such as hospitalizations and nursing facility admissions. An individual using this service must demonstrate a need for observation and evaluation.

When the individual's condition is unstable, could easily deteriorate, or when significant changes occur, the ICO covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the individual's condition and report findings to the individual's physician or other appropriate health care professional such as the ICO Care Coordinator to prevent additional decline, illness, or injury to the individual. The ICO Care Coordinator shall communicate with both the nurse providing this service and the individual's health care professional to ensure the nursing needs of the individual are being addressed.

Individuals must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including individual-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
- Require professional assessment of the individual's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
- Require professional evaluation of the individual's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary.

- Require professional evaluation of the individual's physical status to encourage optimal functioning and discourage adverse outcomes.
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the individual's physician or other health care professional.

In addition to observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Complied Law (MCL) 333.7103(1)).
- Setting up medications according to physician orders.
- Monitoring individual adherence to their medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the individual or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

This service is limited to **no more than two hours per visit.**

Individuals receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services.

All providers must be licensed in the State of Michigan as a RN or LPN.

5.3.M. Private Duty Nursing

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an individual age 21 or older on an individual and continuous basis, **up to a maximum of 16 hours per day**, to meet the individual's health needs directly related to the individual's physical disability.

Medical Criteria

To be eligible for PDN services, the ICO must find the individual meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria below). Regardless of whether the individual meets Medical Criteria I or II, the individual must also meet Medical Criteria III.

- **Medical Criteria I** – The individual is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
  - Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or

- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition (TPN) delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for individuals 21 years of age or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

- **Medical Criteria II** – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions:
  - "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
  - "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
  - "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
  - "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
  - "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.
  - "Substantiated" means documented in the clinical or medical record, including the nursing notes.

- **Medical Criteria III** – The individual requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. Definitions:
  - "Continuous" means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
  - "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
    - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
    - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the individual four or more hours per day;
    - Deep oral (past the tonsils) or tracheostomy suctioning;
    - Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
    - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, or is associated with complex medical problems or medical fragility;
    - TPN delivered via a central line and care of the central line;
    - Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below;
    - Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

All nurses providing PDN to waiver individuals must maintain a current State of Michigan nursing license, and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242. PDN may include medication administration according to MCL 333.7103(1).

This service must be ordered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner. The ICO is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for ensuring the PDN provider has a copy of these orders and delivers PDN services according to the orders. The ICO shall maintain a copy of the physician orders in the Care Bridge Record. The individual's physician, physician's assistant, clinical nurse specialist, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to ensure services are delivered according to that order.

Through a person-centered planning process, the ICO shall determine the amount, scope and duration of services provided. The direct service provider shall maintain close contact with the authorizing ICO to promptly report changes in each individual's condition and/or treatment needs upon observation of such changes. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the individual.

Individuals receiving Preventive Nursing Services are not eligible to receive PDN services.

All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.

5.3.N. Respite

5.3.N.1. Respite Provided at the Individual's Home or in the Home of Another Person

Respite services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who

provide respite services must meet the same standards as providers who are unrelated to the individual.

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in payment for respite services.

5.3.N.2. Respite Provided Outside of the Home

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in MCL 400.701ff, which includes AFC homes and HFA. Respite may include the cost of room and board if the service is provided in a licensed AFC or licensed HFA.

Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Out of home respite may be scheduled for several days in a row, depending upon the needs of the individual and the individual's caregivers.

5.4 Hospice

Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose.

When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting.

A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status.

SECTION 6 – CONTINUITY OF CARE

Individuals enrolled in the MI Health Link program must maintain their current Medicare and Medicaid providers, supports and services for the following timeframes after enrollment: Individuals have the right to continue to see providers who are not in the ICO's network during the Continuity of Care period. Communication between the individual, providers, and the ICO is essential to ensure providers are identified so services can be provided and covered by the ICO. The ICO must work to bring individuals' current providers into the plan's network.

ICO Transition Requirement for Individuals receiving services through the HAB waiver and Managed Specialty Services and Supports Program through the PIHPs	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 180 calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 180 calendar days. The IICSP must be reviewed and updated and providers secured within 180 calendar days of enrollment.

ICO Transition Requirements for All Other Individuals	
Provider Type	**Timeframe for continuing current services**
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for 90 calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 90 calendar days.
Medicaid Nursing Facility Services	Individual may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the individual chooses to relocate.
Waiver Services	MI Choice HCBS waiver individuals: Maintain current providers and level of services at the time of enrollment for 90 calendar days unless changed during the Person-Centered Planning Process. Not applicable to other individuals.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 90 calendar days. The Individual IICSP must be reviewed and updated and providers secured within 90 calendar days of Enrollment. Not applicable for individuals transitioning from the MI Choice program.

The ICO is required to review Medicare and Medicaid utilization data provided by CMS and MDHHS to determine which providers have existing relationships with individuals. Continuity of care protection is automatic for providers which are verified through utilization data to meet the prior relationship requirement.

The individual must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

- **Specialists:** The individual must have seen the specialist at least once within the 12 months prior to enrollment into a ICO for a nonemergency visit.
- **Primary Care Provider:** The individual must have seen the primary care provider at least twice within the 12 months prior to enrollment into a ICO for a non-emergency visit.
- **Other Covered Providers:** The individual must have received services from other providers within the past 12 months prior to enrollment into a ICO.

If the ICO cannot determine if a relationship exists based on the available data, the ICO shall ask the provider and individual to provide documentation of the visit from the medical record or proof of payment to establish the relationship. An attestation that a relationship exists is not sufficient.

The ICO must ask the individual about any upcoming appointments to ensure agreements are in place with out-of-network providers. If data is not available to establish relationship with the individual's provider, the individual or their appointed/legal representative may request continuity of care. The individual's out-of-network provider may also request continuity of care on behalf of the individual. Requests for continuity of care should be made by contacting the ICO's member services department or the individual's ICO Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the ICO.

Generally, ICOs must start processing a request for continuity of care within five working days after the request is received. The ICO has a maximum of 30 days to complete the request. However, if the individual's medical condition requires more immediate attention (e.g., an upcoming appointment); the ICO must complete the request within 15 days. If there is a risk of harm to the individual or rescheduling of the appointment would be required, the request must be completed within three days of the request. The ICO may verbally convey Continuity of Care approval with the requester and record such approval in the individual's record.

If the criteria for the prior relationship as outlined above are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within 30 days of the first date of service.

The ICO must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would cause the ICO to exclude the provider based on state or federal requirements.

Pharmacy

ICOs are required to maintain current prescriptions for medications for 180 days if medications are not on the ICO's formulary unless directed otherwise by CMS and MDHHS. The individual can ask the ICO to make an exception to cover a drug that is not on the ICO's formulary.

Nursing Facilities

Out-of-network nursing facilities must be offered Single Case Agreements by the ICO to continue to care for the individual through the life of the program if the nursing facility does not participate in the ICO's network and the individual: 1) resides in the nursing facility at the time of enrollment; 2) has a family member or spouse that resides in the nursing facility; or 3) requires nursing facility care and resides in a retirement community that includes a nursing facility. This continuity of care protection is available as long as the individual resides in the nursing facility. Continuity of care in a nursing facility is automatic. The individual does not have to make a request for continuity of care. The ICO must refill prescriptions for individuals in a nursing facility for a minimum of 91 days and the ICO must refill the drug multiple times during the first 90 days of enrollment, as needed. This allows the prescriber time to change the drugs to those on the drug list or ask for an exception.

Personal Care Providers

The ICO must allow choice of personal care service providers, including non-financially responsible family members or friends, to provide the service if they meet the criteria to enroll in the ICO's network.

The ICO may enter into an agreement for non-agency personal care providers when a permissible exclusion is identified through a background check. The ICO may allow for this exclusion if the individual is informed of the details of the permissible exclusion and agrees, in writing, to allow the person to provide personal care to the individual during the continuity of care period. During this time period, the individual can seek alternatives to receiving personal care services if the ICO does not continue the agreement beyond the required continuity of care period.

Under no circumstance must the ICO enter into an agreement if it is discovered the personal care services provider falls under the policy for mandatory exclusion from providing personal care services.

Other Providers

Continuity of care does not extend to DME providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to these types of providers, the ICO must still provide continuity of care for services and the ICO is responsible for finding an in-network provider to deliver services without disruption.

SECTION 7 – CARE COORDINATION, ASSESSMENT AND PERSON-CENTERED PLANNING

The MI Health Link program requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, BH, SUD and/or I/DD, pharmacy, and LTSS. This requires coordination between the ICO and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable. The ICO shall contract with the PIHP to deliver Medicare BH, SUD and/or I/DD services to individuals. This contract and any other downstream contracts related to care coordination activities will be monitored by the CMS and MDHHS contract management team to ensure all delivery system requirements of MI Health Link are met and all individuals receive the appropriate care coordination services. To accomplish this, the ICO must:

- Develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative claims data, and other available information to help prioritize and determine the care coordination needs of each individual.
- Focus on providing services in the most integrated and least restrictive setting.
- Maintain flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.
- Exhaust the use of community-based services before utilizing institutional settings for LTSS.
- Wherever possible, include a person familiar with the needs, circumstances and preferences of the individual when the individual is unable to participate fully in or report accurately to the Integrated Care Team (ICT).
- Ensure that the individual has a primary care provider (PCP) appropriate to meet their needs and assist the individual in accessing services.

7.1 THE CARE BRIDGE

The care coordination model for MI Health Link is the Care Bridge, which includes both technology and people through the person-centered planning process. The ICO is required to utilize a care coordination platform supported by web-based technology that is discussed in this section and referred to as the Care Bridge.

The Care Bridge allows secure access to information and enables all individuals and members of the ICT to use and (where appropriate) update information. Through the electronic Care Bridge, the members of the individual's ICT facilitate access to formal and informal supports and services identified in the individual's Individual Integrated Care and Supports Plan (IICSP) developed through a Person-Centered Planning process.

The Care Bridge includes an electronic care coordination platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the ICT. The electronic Care Coordination platform will include a mechanism to alert ICT members of emergency department use or inpatient admissions. The ICBR will allow ICO Care Coordinators, PIHP and LTSS coordinators, where applicable, and providers to post key updates and notify ICT members of changes.

This platform will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other relevant laws, and provide for the exchange of data in a standard format.

The approved electronic care coordination platform will generate and maintain an individualized individual record referred to as ICBR including:

- Current integrated condition list;
- Contact information for the ICO Care Coordinator and ICT members;
- Current medications list;
- The date of service and the name of the provider for the most recently provided services;
- Historical and current utilization and claims information;
- Historic Medicaid and Medicare utilization data: MDHHS will provide the ICO with access to the CareConnect360 (CC360) system to view and extract historic utilization data.
- MDHHS will initially provide the ICO with extract files containing historical data for all individuals for the previous 24 months. Updates thereafter are available on a monthly basis or by the frequency identified by the ICO.
- Initial screening, Assessments (Level I and Level II), nursing facility LOCD and Personal Care Assessment results;
- Service outcomes, including specialty provider reports, lab results, and emergency room visits;
- IICSP; and
- Notes and correspondence across provider settings.

7.2 Health Promotion and Wellness Activities

The ICO must provide a range of health promotion and wellness informational activities for individuals, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavior in the Medicare-Medicaid population. Interpreter services must be available for individuals who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to, the following:

- Chronic condition self-management;
- Smoking cessation;
- Nutrition; and,
- Prevention and treatment of alcohol and substance abuse.

7.3 Integrated Care Team (ICT)

Every individual shall have access to and input in the development of an ICT to ensure the integration of all the individual's supports and services, including medical, behavioral, psychosocial, and LTSS. The ICT will be person-centered, respecting and incorporating the individual's specific preferences and needs. The ICT will deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The ICT will honor the individual's choice about their level of participation and interaction with the ICT. This choice will be periodically revisited with the individual by the ICO Care Coordinator.

7.3.A. Integrated Care Team Members

The ICO Care Coordinator will lead the ICT. It will be the responsibility of the ICO Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between ICOs, PIHPs and other providers. While the ICO Care Coordinator will be the ICT lead, the individual may request the LTSS or PIHP Supports Coordinator remain their main point of contact regarding the ICT.

ICT membership will include the individual and the individual's chosen allies, ICO Care Coordinator, primary care physician, and LTSS Supports Coordinator or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary at each meeting depending on the changing needs of the individual. PCPs may designate a licensed medical professional on their staff who has personal knowledge of the enrollee's condition(s) and health care needs to attend in place of the PCP. The ICT may also include the following persons as needed and available:

- Family caregivers and natural supports
- Primary care nurse care manager
- Specialty providers
- Personal care providers
- Hospital discharge planner
- Nursing facility representative
- Others as appropriate

7.3.B. Integrated Care Team Responsibilities

The role of ICT is to work collaboratively with the individual to meet goals identified in the IICSP and ensure the best possible health care outcomes. The ICO Care Coordinator is responsible to ensure the completion of tasks listed below for the ICT. ICT members will:

- Ensure the IICSP is developed, implemented, and revised according to the person-centered planning process and the individual's stated goals, including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.
- Participate in the Person-Centered Planning process at the individual's discretion to develop the IICSP;
- Collaborate with other ICT members to ensure the Person-Centered Planning process is maintained;
- Assist the individual in meeting their goals;
- Monitor and ensure that their part of the IICSP is implemented in order to meet the individual's goals;

- Update the ICBR as needed pertinent to the ICT member's role on the ICT;
- Review assessment, test results and other pertinent information in the ICBR;
- Address transitions of care when a change between care settings occur;
- Ensure continuity of care requirements are met; and
- Monitor for issues related to quality of care and quality of life.

The operations of ICTs will vary depending on the needs and preferences of the individual. An individual with extensive service needs may warrant periodic meetings with all ICT members. An individual with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with ICT members. The ICO Care Coordinator is responsible for facilitating communication among the ICT members.

The ICT will adhere to an individual's determination about the appropriate involvement of their medical providers and caregivers at each meeting according to HIPAA and, for individuals in SUD treatment, 42 CFR Part 2.

7.4 ICO Care Coordinator

ICO Care Coordinators must have the experience, qualifications and training including MDHHS required training appropriate to the needs of the individual, and the ICO must establish policies for appropriate assignment of ICO Care Coordinators.

ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

The ICO Care Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed clinical nurse specialist;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Limited license Bachelor's prepared social worker;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or
- Licensed Master's prepared social worker.

ICO Care Coordinator Training

The ICO Care Coordinator will participate in train-the-trainer Person-Centered Planning and Self-Determination educational opportunities offered by MDHHS. The ICO will be responsible for training any new ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDHHS and ICO trainings as required.

The ICO will participate, train and report on any other training required or offered by MDHHS or its designee.

ICO Care Coordinator Responsibilities

The ICO Care Coordinator will be responsible for care coordination for each individual. The ICO Care Coordinator will conduct the Level I Assessment, ensure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT.

The ICO Care Coordinator will be responsible to:

- Support an on-going person-centered planning process;
- Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and completion of or referral for a Level II Assessment (as appropriate);
- Facilitate timely access to primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the individual, including referrals to address any physical or cognitive barriers or referrals to the PIHP;
- Create and maintain an ICBR for each individual to manage communication and information regarding referrals, transitions, and care delivery;
- Facilitate communication among the individual's providers through the use of the care coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;
- Notify the ICT of the individual's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;
- Facilitate face-to-face meetings, conference calls, and other activities of the ICT as needed or requested by the individual;
- Facilitate direct communication between the provider and the individual or the individual's authorized representative and/or family or informal supports as appropriate;
- Facilitate individual and family education;
- Coordinate and communicate, as applicable, with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;
- Develop, with the individual and ICT, following the person-centered planning process, an IICSP specific to individual needs and preferences, and monitor and update the IICSP at least annually or following a significant change in needs or other factors;
- Coordinate and make referrals to community resources (e.g., housing, home delivered meals, energy assistance programs) to meet IICSP goals;

- Perform ongoing care coordination;
- Monitor the implementation of the IICSP with the individual, including facilitating the individual's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;
- Advocate with or on behalf of the individual, as needed, to ensure successful implementation of the IICSP;
- Support transitions in care when the individual moves between care settings including:
  - The ICO Care Coordinator will contact the individual once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community.
  - The ICO Care Coordinator will ensure immediate and continuous discharge planning, including electronic and verbal communication, with the individual and ICT members following an individual's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the individual when discharged. This includes scheduling an outpatient appointment, ensuring the individual has all necessary medications or prescriptions upon discharge, and conducting follow-up with the individual and/or caregiver.
  - The Care Coordinator shall make every effort to ensure that home and community based services are in place upon hospital discharge to avoid unnecessary nursing facility placements. The ICO Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to ensure prompt initiation of appropriate HCBS. If the individual is being discharged from a nursing facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.
  - Evaluating Section Q of the Minimum Data Set (MDS) for individuals currently in a nursing facility and discussing options for returning to the community, revising the IICSP, and transitioning the individual to the most integrated setting.
  - The ICO Care Coordinator will inform the individual of their right to live in the most integrated setting, inform the individual of the availability of services necessary to support their choices, and record the home and community-based options and settings considered by the individual.
  - Engage in other activities or services needed to assist the individual in optimizing their health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status.
  - Ensure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits.
  - If the individual is receiving services that require meeting the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) standards, ensure through required Level I and/or Level II assessments that the individual continues to meet the criteria or transitions to services that do not require LOCD standards. The ICO Care Coordinator will ensure appropriate assessments are conducted for individuals

with identified long term care needs, and MDHHS will make final eligibility determinations, unless otherwise directed by the State and CMS.

Individual ICO Care Coordinator Assignments and Change Requests

- The ICO shall allow the individual or their authorized representative choice in ICO Care Coordinator.
- The ICO shall ensure every individual has an ICO Care Coordinator with the appropriate experience and qualifications based on the individual's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).
- The ICO must have a process to ensure that an individual or their authorized representative is able to request a change in their ICO Care Coordinator at any time, including a process for the transition from one ICO Care Coordinator to another.
- The ICO must establish policies for appropriate assignment of ICO Care Coordinators to align with the individual's known or expressed cultural, religious and ethnic preferences by considering the knowledge and experience of the ICO Care Coordinator.

7.5 Coordination with PIHP and LTSS Supports Coordinators

The ICO Care Coordinator must collaborate with the applicable PIHP Supports Coordinator or identified behavioral health representative as defined in the contract between the ICO and the PIHP when:

- The individual has received services through a PIHP within the last 12 months, or
- A new individual requests, or is identified as having potential need for, BH, I/DD, or SUD services.

If the individual has need of LTSS, the ICO Care Coordinator will collaborate with the individual's chosen LTSS Supports Coordinator when:

- The individual has received LTSS within the last 12 months, or
- A new individual requests or is identified as having potential need for LTSS.

7.5.A. LTSS Supports Coordinator

LTSS Supports Coordinator will be offered to all individuals who have needs for long term supports and services. The LTSS Supports Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed clinical nurse specialist;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Limited license Bachelor's prepared social worker;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or

- Licensed Master's prepared social worker.

The LTSS Supports Coordinator must:

- Have knowledge of HCBS;
- Have completed a person-centered planning and person-centered direction training;
- Be culturally competent;
- Be able to provide information regarding the quality ratings and licensure status, if applicable, of available options;
- Be knowledgeable about risk factors and indicators of, and resources to respond to, abuse and neglect;
- Be familiar with applicable long term care facility licensing requirements and resources such as the long term care ombudsman program; and
- Have experience conducting LTSS needs assessments.

LTSS Supports Coordinator Responsibilities

The ICO will be responsible to provide, directly or contractually, the following LTSS Supports Coordination services:

- Support an on-going person-centered planning process;
- Assist the individual to take a lead role in the person-centered planning process;
- Provide information to the individual and ICT;
- Communicate and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment;
- Participate in the assessment process as needed, including conducting the Level II Assessment specific to the individual's needs;
- Participate on the individual's ICT;
- Develop, with the individual and the ICT, an IICSP;
- Ensure optimal utilization of information and community supports;
- Arrange services as identified in the IICSP;
- Update the ICBR with current individual status information to manage communication and information flow regarding referrals, transitions, and care delivery;
- Monitor service implementation, service outcomes, and the individual's satisfaction;
- Collaborate with the ICO Care Coordinator to assist the individual during transitions between care settings, including full consideration of all community options; and
- Advocate for the individual and support self-advocacy by the individual.

The ICO Care Coordinator may serve as the LTSS Supports Coordinator and complete the required functions of both roles.

7.6 Assessment Tools and Process

7.6.A. Individual Stratification

The ICO will develop and implement a strategy that uses a combination of initial screenings, assessments, assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of care coordination needed by each individual.

The ICO must review program level data through CHAMPS and CareConnect360 or through file exacts provided by MDHHS as part of the initial screening process. CareConnect360 contains past Medicare and Medicaid utilization data from the MDHHS Data Warehouse. The ICO must review program level data and utilization data within 15 calendar days of enrollment.

Levels of stratification should be based on:

- Individual demographics, medical conditions, functional status, care patterns, resource utilization data.
- The individual's risk for long term care institutionalization or avoidable hospitalization.
- Individuals receiving services in the Habilitation Supports Waiver (HSW) or an individual transitioning to MI Health Link from the MI Choice waiver are automatically stratified as high risk.
- The ICO will determine the parameters and definitions for other individuals defined as high risk as well as definitions for low or moderate risk individuals.

The ICO may also choose to use existing predictive modeling software to support the screening and assessment requirements are not be required to do so.

7.6.B. Initial Screening

The purpose of the initial screening is to identify individuals with immediate needs in order to prioritize in-person Level I Assessments. The initial screening is a series of individual reported yes/no questions related to historical and current service usage. This screening is conducted via telephone when individuals call the enrollment broker to enroll in MI Health Link.

For those individuals passively enrolled into the ICO or those not completing the screen during the enrollment call, the ICO must make its best efforts to administer the initial screening within 15 calendar days of enrollment.

The ICO must document attempts in the ICBR to contact the individual for the purpose of scheduling or conducting the initial screening on different days of the week and at different times during the day, including times outside of standard work hours. If the initial contact is not made within 15 calendar days of enrollment, the ICO must continue efforts to contact the individual and document such in the ICBR.

The ICO will review the individual's responses to the initial screening questions to identify current utilization of PIHP services, nursing facility care, community-based supports and services, and hospital care (inpatient or emergency room treatment).

The ICO must document the individual's responses to the initial screening questions in the ICBR.

7.6.C. Level I Assessments

Each individual must receive, and be an active participant in (to the extent they desire), a timely Level I Assessment of medical, behavioral health, psychosocial, and LTSS needs completed by the ICO Care Coordinator unless one of the following circumstances applies:

- An individual declines an assessment. Should that occur, the ICO will honor the individual's decision and will only contact the individual regarding an assessment if the individual requests one or a new assessment is needed according to the reassessment requirements.
- An individual is not reachable through the contact information provided by MDHHS or CMS. The ICO must document its attempts to reach the individual and what means of communication were used.
  - The ICO shall attempt to contact the individual at least five times within the first 60 days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.
  - ICO shall use community resources where possible to identify and engage individuals.
- The ICO Care Coordinator will identify, through the Level I Assessment, individuals who may require institutional level of care or personal care services.
- The ICO will perform the Level I Assessment using its tool approved by MDHHS to assess each individual's current health, welfare, functional needs and risks.
- The ICO will use the DSM-5 screening tool as part of or in addition to its Level I Assessment tool to identify Individuals with BH, SUD, and/or I/DD needs.

The ICO Care Coordinator may complete the Level I Assessment in lieu of the initial screening if the Level I Assessment is completed within 15 calendar days of enrollment.

Level I Domains

Level I Assessment domains must include, but not be limited to, the following:

- Individual preferences, strengths, and goals including Self-Determination arrangements;
- Natural supports, including family and community caregiver capacity, and social strengths and needs;
- Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and individual health literacy;

- Current services, including those covered by Medicare and Medicaid, community supports, and care transition needs;
- Medical health risk, status, and history, including but not limited to medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections;
- BH and SUD risk status; BH, SUD, and I/DD history and needs, including medications;
- Nutritional strengths and needs;
- ADL and IADL, including any assistive technology used or needed and immediate environmental or housing needs;
- Cognitive strengths and needs;
- LTSS;
- Quality of life including physical, mental, and psycho-social well-being;
- Discussion and education related to abuse, neglect, and exploitation; and
- Advance Directives

The ICO may include State-approved domains as appropriate. Additional domains should be included in the ICO's Level I Assessment tool when submitting the tool for approval by MDHHS.

Involvement in the Level I Assessment

The Level I Assessment will be completed by the ICO Care Coordinator (see qualifications above) employed or contracted with the ICO who is accountable for providing Care Coordination services. The ICO may delegate through contract with entities or individuals meeting the Care Coordinator qualifications for performance of Initial Screenings, Level I Assessments and LTSS Level II Assessments, as well as Care Coordination functions. The ICO retains responsibility and accountability for utilization management functions, appeals, and approval of services. The Care Coordinator role cannot be delegated through contract or other means to Long Term Supports and Services providers who are otherwise responsible for providing services to individuals, such as nursing facilities.

- The ICO will include the appropriate PIHP or LTSS Supports Coordinator or nursing facility staff in conducting the Level I Assessment if the individual has been active in the PIHP or LTSS system during the previous 12 months or is currently residing in a nursing facility.
- Family members or other individuals may also be included in the Level I Assessment process to the extent desired by the individual.

Level I Results and Referral

The ICO will use the results of the Level I Assessment to confirm the appropriate acuity or risk stratification level for individual Care Coordinator assignments. The Level I Assessment and the DSM-5 screening tool for BH, SUD, I/DD, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.

The ICO will make referrals according to the process identified in ICO/PIHP contract to the PIHP/BH system for individuals identified as having BH, SUD, and/or I/DD needs.

The PIHP will conduct in person or adopt current Level II Assessments for individuals identified as receiving services from the Habilitation Supports Waiver and/or the Specialty Services and Supports Program. The PIHP will conduct a telephonic screen using the MDHHS approved tool to determine:

- If the individual has mild to moderate needs that can be met through referral for additional services; or
- If the individual has needs that require the Level II Assessment.

The PIHP will coordinate service referrals to ICO or PIHP network providers or conduct further assessment as needed. The PIHP will document the results from the telephonic screen and referral in the ICBR.

The ICO Care Coordinator is responsible for ensuring completion of further assessment for individuals with medically complex conditions. The ICO will coordinate with the primary care provider to ensure that further follow-up relevant to these needs is provided to the individual.

The individual will continue to receive any services in any existing care plan prior to the Level I Assessment. The ICO will adhere to all transition requirements for services, as outlined in the Continuity of Care section and any other documentation provided by CMS or MDHHS.

Level I Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

Timing of Level I Assessments

Level I Assessments will be completed within 60 calendar days of enrollment. ICOs approved by CMS and MDHHS to conduct early Level I Assessment may start the assessment no earlier than 20 days before the enrollment effective date. Early assessment does not impact the time frames for completing other assessments. Other Assessments cannot be completed before the enrollment effective date. Individuals identified with immediate needs or as having high risk should have Level I Assessments completed earlier than 60 calendar days from enrollment, as appropriate.

In-person Level I Assessments

The ICO Care Coordinator is encouraged to conduct the Level I Assessment in person. Individuals identified with immediate needs or as having high risk will have assessments completed in person.

Locating Individuals

The ICO shall identify individuals through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and ICO personnel. The ICO shall notify the primary

care provider (PCP) of an individual who has not completed a Level I Assessment within the time period set forth above and whom the ICO has been unable to contact. The ICO shall encourage the PCPs to conduct outreach to these individuals and to schedule visits. The ICO shall collaborate with clinics, hospitals, or urgent care centers to identify individual contact information for individuals the ICO has not been able to contact.

7.6.D. Triggers from the Level I Assessment

Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

The Michigan Medicaid Nursing Facility Level of Care Determination tool must be conducted for all individuals according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in the Medicaid policy (refer to the Nursing Facility Level of Care Determination Chapter of the Medicaid Provider Manual) and additional guidance provided by MDHHS. For the MI Health Link program only, the Nursing Facility Level of Care Frailty Review criteria will be applied at the time the LOCD is conducted for the individual if the individual does not meet LOCD criteria under Doors one through seven. Additionally, for the MI Health Link program, the LOCD must be conducted by a Care Coordinator holding a credential as described in the ICO Care Coordinator subsection of this chapter.

PIHP Telephonic Screen

The ICO shall refer individuals identified in the Level I screen as having BH, SUD or I/DD needs to the PIHP for additional assessment. Of this population, those individuals without a known history of PIHP services will receive a telephonic screen to determine service needs. The PIHP will determine if the individual has mild to moderate needs which can be addressed through additional assessment or referral to providers (PIHP or ICO). For all other individuals, the PIHP will complete the appropriate Level II assessment. The PIHP has flexibility to perform the telephonic screening function within the current intake system as long as identification of needs is completed using the prescribed tool.

7.6.E. Level II Assessment

The ICO Care Coordinator will collaborate with the PIHP to ensure that the Level II Assessment is conducted for individuals identified through the telephonic screen as needing referral to the PIHP for Level II Assessment. The ICO Care Coordinator will ensure that the Level II Assessment is conducted for individuals demonstrating LTSS needs identified in the Level I Assessment.

Level II assessments must be completed using the tools approved by MDHHS.

Qualifications for Completing Level II Assessment

Level II Assessments will be conducted by professionally knowledgeable and trained LTSS Supports Coordinators or PIHP Supports Coordinators or behavioral health case managers, who have experience working with the population. Each Level II Assessment tool has specific qualifications for the person completing the tool.

Timing of Level II Assessments

Any Level II Assessment completed prior to enrollment by the PIHP Supports Coordinator, a trained LTSS Supports Coordinator or a behavioral health case manager may be adopted if it is not past the reassessment date. The Level II Assessment should be reviewed to determine if it is complete, accurate and appropriate for the individual's current status. Level II Assessments will be conducted in person within 15 calendar days of completion of the Level I Assessment. Level II Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.6.F. Reassessments

7.6.F.1. Level I Reassessments

The ICO is responsible to ensure that an annual Level I reassessment for each individual (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within 12 months of the last Level I Assessment. If prior to the annual reassessment, the individual experiences a major change impacting health status, the ICO is required to reassess the individual and review and revise the IICSP with members of the ICT as needed. The ICO must ensure that a reassessment and an IICSP update are performed:

- As warranted by the individual's condition but at least every 12 months after the Level I Assessment completion date;
- When there is a change in the individual's health status or needs; and
- As requested by the individual, their caregiver or authorized representative, or their provider.

The ICO will analyze utilization data of all individuals monthly to identify acuity and risk level changes. As acuity and risk levels change, reassessments will be completed as necessary and IICSP and interventions updated and documented in the ICBR.

The ICO is responsible to complete a reassessment as often as desired by the individual and update the IICSP with members of the ICT as needed. The ICO is encouraged to conduct reassessments in person.

7.6.F.2. Level II Reassessments

Level II reassessments will be completed according to the reassessment timeframe of each assessment tool utilized. For assessments adopted at the time of enrollment, the next assessment date with follow the annual scheduled described above for each tool unless the individual has a significant change of conditioning requiring a new assessment.

For individuals receiving nursing facility level of care services, the reassessment must confirm that the individual continues to meet the Michigan Medicaid Nursing Facility LOCD standards. If the standards are not met, a new LOCD tool must be completed to allow the individual rights to an appeal. The ICO will initiate planning for transitioning

the individual to more appropriate supports and services. Reassessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.7 Care Planning

Individual Integrated Care and Supports Plan (IICSP)

The ICO Care Coordinator, individual, providers, and other ICT members develop a comprehensive, person-centered, written IICSP for each individual. The person-centered planning process must be conducted in-person unless the individual chooses otherwise. The individual may choose to participate in person-centered planning to the extent they desire.

Every individual must have an IICSP. The IICSP should be developed based on the outcome of the person-centered planning meeting unless the individual chooses not to participate and the refusal to participate is documented in the IICSP and ICBR. At a minimum the ICO Care Coordinator or Supports Coordinator must provide their contact information to the individual and re-visit the opportunity to participate in person-centered planning and development of the IICSP at the time of reassessment, a change of condition, or upon the individual's request.

The ICO must complete the initial IICSP within 90 calendar days of enrollment. Existing person-centered service plans or plans of care may be incorporated into the IICSP. The ICO must review the adopted plan with the individual to determine if revisions are necessary to address the individual's goals and meet the individual's needs. The IICSP must be contained in the ICBR and shared with the individual and the ICT.

The ICO must discuss advance directives with the individual including the choice to execute a directive, its incorporation in the IICSP, and assurance of provider knowledge of the individual's directive.

The IICSP must:

- Focus on supporting the individual to achieve personally defined goals in the most integrated setting;
- Be developed following MDHHS principles for person-centered planning;
- Include the individual's preferences for care, services, and supports;
- Include the individual's prioritized list of concerns, goals and objectives, and strengths;
- Include specific providers, supports and services including amount, scope, and duration;
- Include a summary of the individual's health status;
- Include the plan for addressing concerns or goals and measures for achieving the goals;
- Include person(s) responsible for specific interventions, monitoring, and reassessment; and
- Include the due date for the interventions and reassessment.

IICSP Monitoring

The ICO will review the individual's IICSP to ensure the IICSP continues to meet the individual's needs and is updated accordingly.

- The ICO must review IICSPs of high-risk individuals least every 30 calendar days.
- The ICO must review IICSPs of moderate-risk individuals at least every 90 calendar days.
- The ICO must review IICSPs of low-risk individuals at least every 180 calendar days.

The ICO will make contact with the individual to inquire if the IICSP continues to meet the individual's needs. This contact may be telephonic, unless in-person contact is requested by the individual. For high-risk enrollees, the IICSP review must be completed in person at least quarterly. For moderate-risk enrollees, at least every other IICSP review must be completed in person. Low-risk enrollees must be offered the opportunity for an in-person IICSP review. If the low-risk enrollee does not wish to have an in-person IICSP review, the ICO Care Coordinator may conduct a telepresence or telephonic visit with the enrollee. The ICO must update the individual's IICSP at least annually and more frequently if conditions warrant, or if an individual requests a change.

SECTION 8 – CRITICAL INCIDENT REPORTING

The ICO must report critical incidents to MDHHS and other authorities as required by CMS and the State.

8.1 TYPES OF CRITICAL INCIDENTS THAT NEED TO BE REPORTED

ICOs must report the following:

- Exploitation
- Illegal activity in the home
- Medication Errors
- Neglect
- Physical Abuse
- Provider no shows
- Restraints, Seclusion, or restrictive interventions
- Sexual Abuse
- Suspicious or Unexpected Death
- Theft
- Verbal Abuse
- Worker consuming drugs or alcohol on the job

SECTION 9 – MI HEALTH LINK HCBS WAIVER

The MI Health Link HCBS waiver offers home and community-based services to allow MI Health Link individuals to remain in the community instead of an institution. MI Health Link individuals who require services through this waiver must apply to MDHHS and be approved for enrollment. ICOs or their subcontractors, according to a contractual agreement, must submit an application to MDHHS for review and approval. Waiver eligibility must be re-determined on an annual basis.

Waiver enrollment is limited to a certain number of individuals that has been approved by CMS.

9.1 APPLICATION PROCESS

When a MI Health Link individual is interested in participating in the MI Health Link HCBS waiver, the ICO must submit an application packet to MDHHS for review and approval prior to an individual participating in the waiver. Applications may be submitted to MDHHS electronically via the Waiver Support Application system or via hard copy paper format using U.S. Mail, United Postal Service, FedEx, or fax as directed by MDHHS.

The ICO will be notified by MDHHS of the outcome of the application review, approval, or rejection via telephone, email, U.S. Mail, or the electronic Waiver Support Application system.

9.2 PERSON-CENTERED PLANNING

The person-centered planning process and IICSP for MI Health Link HCBS waiver individuals must be compliant with the Home and Community-Based Services (HCBS) Final Rule (CMS-2249F; CMS- 2296-F) that was released by CMS on January 16, 2014. At a minimum, the IICSP must include the following components:

- The ICO must develop the IICSP before providing services.
- The individual must approve of all services in the service plan.
- The ICO must document individual approval and participation on the IICSP, including:
  - Individual's preferences for care, services, supports, residential settings, and non-residential settings.
  - Supports and services options that were discussed with the individual and their (or legal representative's) choice of those services and providers.
  - When the individual selects controlled residential settings such as licensed AFC or HFA, the following must be included in the IICSP:
    - The chosen setting.
    - The individual's resources.
    - Whether or not the individual chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, etc.
    - Preference for engaging in community activities outside the home, and whether or not the individual needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen.

- Personal safety risks and any interventions that may affect the individual's ability to engage in community activities outside the home without supervision.
- Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an individual's assessed needs; indicate established timeframes for periodic review of these modifications.

- Individual's health and safety risks.
- Individual's prioritized list of concerns, goals and objectives, strengths.
- Summary of the individual's health status.
- The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services, including amount, scope and duration.

- The individual's (or legal representative's) rights and choices of specific providers (and alternative providers, if necessary).
- A contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies.
  - Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes.
  - Individual's informed consent.
  - Due date for interventions and reassessment.

The IICSP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The amount (units), frequency, and duration of each waiver service to be provided are included in the IICSP. The individual chooses the supports and services that best meet their needs and whether to use the option to self-direct applicable services or rely on a ICO Care Coordinator and/or LTSS Supports Coordinator to ensure the services are implemented and provided according to the IICSP. When an individual chooses to participate in arrangements that support self-determination, information, support and training are provided by the ICO Care Coordinator and/or LTSS Supports Coordinator and others identified in the IICSP and according to the Self-Determination Implementation Technical Advisory. When an individual chooses not to participate in self-determination, the ICO Care Coordinator or LTSS Supports Coordinator ensures that supports and services are implemented as planned. The ICO Care Coordinator and/or LTSS Supports Coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the IICSP. This oversight ensures that waiver services in the IICSP are not duplicative of similar State Plan services available to or received by the individual.

An electronic method of signing off on required documents such as the person-centered service plan is acceptable. When this method is utilized, the signature must be newly obtained each time the signature is required. The electronic signature cannot be stored and re-used at will.

In-person visits are valued as a means to support the health and welfare of enrollees as well as integration into the community. All assessments and reassessments, and at least one monthly contact a quarter, are to be completed in-person. If the enrollee has an exposure or condition for which a federal, state, or local public health or government official(s) has released applicable quarantine or isolation guidelines, care coordination contact and activities may be made via a HIPAA-compliant virtual method

(video only) in lieu of in-person during the quarantine or isolation period only. If assessments are completed via virtual method (audio and video only; cannot be only audio) during quarantine/isolation, any sections of the assessment(s) related to physical function that normally require in-person observation by the assessor must be reviewed at the next in-person visit to ensure accuracy. Additionally, the enrollee's privacy must be protected during virtual visits. Video recording is not allowed. The Integrated Care Organization (ICO) should support enrollees who need assistance with using the technology required for virtual video contacts through education and training. Written or electronic consent must be obtained from the enrollee for use of the virtual option. Consent and education for virtual visits (during quarantine/isolation) may be obtained at any point ahead of the virtual method being utilized.

9.3 Home and Community-Based Residential and Non-Residential Settings

The HCBS Final Rule (CMS-2249F; CMS-2296-F) applies to 1915(c) waiver programs. The ICO has been provided with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. The ICO, and its subcontractors as appropriate, must be familiar with all aspects of the HCBS Final Rule as it applies to the MI Health Link HCBS waiver. All residential settings in which MI Health Link HCBS waiver individuals live must comply with the requirements of the HCBS Final Rule. Similarly, non-residential settings, such as Adult Day Program settings, must comply with the HCBS Final Rule. Residential and non-residential settings must be immediately compliant with the HCBS Final Rule for the MI Health Link program. This compliance will be assessed prior to the individual's enrollment in the waiver. The ICO must utilize the standard statewide Provider Survey tool produced by MDHHS, and this survey must be conducted in-person with the provider and as directed otherwise by MDHHS. Licensed settings used for the Respite service do not need to be assessed unless the individual stays in the setting for more than 30 days.

9.4 Self-Determination

Self-Determination provides MI Health Link HCBS waiver individuals the option to direct and control their own waiver services. For those MI Health Link HCBS waiver individuals who choose to participate in arrangements that support self-determination, the individual (or chosen representative(s)) has decision-making authority over providers of waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring
- Hiring staff
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the individual's needs and preferences so long as such qualifications comply with those described in the 1915(c) waiver application approved by CMS, and any additional guidance provided by MDHHS
- Specifying how services are to be provided and determining staff duties consistent with the service guidelines as indicated in the CMS-approved waiver application and additional guidance provided by MDHHS
- Determining staff wages and benefits, subject to State and federal limits if applicable
- Scheduling staff and the provision of services

- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff from providing services
- Reallocating funds among services included in the individual's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Budget development for individuals using arrangements that support self-determination occurs during the person-centered planning process and is intended to involve any persons chosen by the individual. Planning for the individual's IICSP precedes the development of the individual's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. An individual's budget is not authorized until the individual and the ICO have agreed to the amount and its use. In the event that the individual is not satisfied with the authorized budget, they may reconvene the person-centered planning process. Fiscal Intermediary services are available through the waiver to help individuals more fully exercise control over their services.

At any time, the individual may modify or terminate the arrangements that support self-determination.

The individual, their chosen allies, the ICO Care Coordinator and LTSS Supports Coordinator must all work together to identify challenges and address problems that may be a barrier to a successful self-determination arrangement. The decision of an individual to terminate participation in self-determination does not alter the supports and services identified in the IICSP. When the individual no longer wishes to participate in self-determination, the ICO must assume responsibility for ensuring the provision of those services through its network of contracted provider agencies while still maintaining and honoring the individual's choice of providers to extent possible.

An ICO may terminate self-determination for an individual when problems arise due to the individual's inability to effectively direct supports and services. Prior to terminating a self-determination agreement (unless it is not feasible), the ICO informs the individual in writing of the issues that have led to the decision to terminate the arrangement. The ICO will continue efforts to resolve the issues that led to the termination.

9.5 Waiver Support Application System

The ICO must utilize the waiver management database in the Waiver Support Application (WSA) system for anything related to MI Health Link HCBS Waiver enrollments, application submission, slot management, and disenrollments. The ICO is required to submit a list of users for this system, and the ICO must keep the list updated on a regular basis as staff come onboard or leave. When approved users leave the organization, the organization must notify the appropriate person as directed by MDHHS.

SECTION 10 – CRIMINAL HISTORY REVIEWS

Each ICO and direct provider of home-based services must conduct a criminal history review through the Michigan State Police (ICHAT), at a minimum, for any paid or volunteer individuals who will be entering the individual's residence. The ICO and direct provider must have completed reference and criminal history reviews before authorizing the person providing services in an individual's residence. At a minimum, the scope of the reference and criminal history investigation is statewide.

ICOs and MDHHS will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.

SECTION 11 – USE OF RESTRAINTS, SECLUSION, AND RESTRICTIVE INTERVENTIONS

Providers are prohibited from using methods of seclusion, restraint, and/or other restrictive interventions. MDHHS will conduct site reviews to ensure these methods are not used. ICO Care Coordinators and LTSS Supports Coordinators, as applicable, have the primary responsibility for identifying and addressing the use of seclusion, restraints, and/or restrictive interventions.

SECTION 12 – PROVIDER PARTICIPATION

Providers have the opportunity to participate in MI Health Link by joining the provider networks of the ICOs. ICOs are encouraged to contract with existing service providers for individuals eligible for and enrolling in the program to ensure continuity of care. Likewise, service providers are encouraged to participate in ICO networks to provide choice, continuity of care and high quality service. The ICO will be responsible for authorizing and paying for Medicare and Medicaid services. Additional information regarding how providers may participate in MI Health Link can be found on the MI Health Link website. (Refer to the Directory Appendix for website information.)

SECTION 13 – MEDICAID POLICY

Current and future Medicaid policies are applicable to the Medicaid portion of the MI Health Link benefit package unless otherwise specified in this chapter or other policies or guidance.

SECTION 14 – QUALITY ASSURANCE

ICOs and PIHPs, as applicable, must comply with requirements set forth in the three-way contract, MI Health Link waiver applications approved by CMS, any other supporting documentation, and the contracts between the ICOs and PIHPs.

SECTION 15 – APPEALS

The three-way contract establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the ICO or contracted entities that would fall under the grievance or appeals processes available to individuals through Medicare and Medicaid guidelines.

SECTION 16 – OMBUDSMAN

ICOs and providers must work with the MI Health Link Ombudsman to resolve enrollment and service issues. ICOs must provide the Ombudsman contact information in their member materials.

NON-EMERGENCY MEDICAL TRANSPORTATION

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SECTION 1 – INTRODUCTION

This chapter applies to non-emergency medical transportation (NEMT) providers and authorizing parties. The Medicaid NEMT benefit is covered for Medicaid, MIChild, and Healthy Michigan Plan (HMP) beneficiaries, and for Children's Special Health Care Services (CSHCS) beneficiaries who also have Medicaid coverage.

Federal law at 42 CFR 431.53 requires Medicaid to ensure necessary transportation for beneficiaries to and from services that Medicaid covers. The NEMT benefit must be administered to beneficiaries in an equitable and consistent manner.

Beneficiaries are assured free choice in selecting a Medicaid medical provider to render services. A beneficiary's free choice of medical provider selection does not require the Medicaid program to cover transportation beyond the standards of coverage described in this policy in order to meet a beneficiary's personal choice of medical provider.

Forms referenced in this chapter are accessed via the beneficiary's case worker and are maintained on MI Bridges.

SECTION 2 – COMMON TERMS

Authorizing Party	An affiliated entity of the Medicaid program (e.g., local MDHHS office or Medicaid-contracted transportation broker) responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.
Commercial Provider	A transportation provider who uses a motor vehicle that belongs to a company or corporation to provide transportation services to a beneficiary.
Daily Long Distance Trip	A daily trip that exceeds 50 miles one-way from the beneficiary's home.
Demand Response (Dial A Ride) Public Transportation	Public transportation characterized by the following: ▪ The vehicles do not operate over a fixed route or on a fixed schedule except, perhaps on a temporary basis, to satisfy a special need, and ▪ Typically, the vehicle may be dispatched to pick up several passengers at different pick-up points before taking them to their respective destinations and may even be interrupted en route to these destinations to pick up other passengers.
Fixed Route Public Transportation	Services provided on a repetitive, fixed schedule basis along a specific route with vehicles stopping to pick up and deliver passengers to specific locations.
Individual With a Vested Interest	A transportation provider who is a relative or friend of a beneficiary and who has a personal stake or interest in the livelihood of a beneficiary.
Long-Term Care Resident	A beneficiary who resides in a Medicaid-certified nursing facility, State Veterans' Home, county medical care facility, or hospital long-term care unit.
Medi-Van	A vehicle owned by a commercial or nonprofit provider used to transport a beneficiary who is able to ambulate and transfer into and out of the vehicle, but requires door-to-door or curb-to-curb service due to their medical condition. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.
Medically Necessary Attendant	An individual, other than the driver of the vehicle or an individual with a vested interest, who assists a beneficiary due to their physical, mental, or developmental status on trips to and from a service or appointment that Medicaid covers.
Nonprofit Provider	A transportation provider who utilizes a motor vehicle that belongs to an entity that has been organized to carry out a charitable, educational, religious, or scientific purpose, and meets specific tax-exempt purposes to provide transportation services to a beneficiary.
Paratransit Transportation	Wheelchair-accessible, demand response services provided by public transportation agencies.
Prolonged Treatment	Medical treatment that is required to treat a medical condition which lasts more than 12 weeks.

Public Transportation Provider	An individual employed by a public entity that provides regular or special continuing transportation available for use by the general public. This does not include school bus, charter, or intercity bus or passenger rail transportation.
Round Trip	When a beneficiary is transported from their residence, or another location, to a Medicaid-covered service and then returned to their original point of origin.
Transportation Provider	An individual (e.g., an employee of a public, commercial, or nonprofit transportation entity, volunteer driver, individual with a vested interest, or medically necessary attendant) who provides transportation services to beneficiaries.
Trip	One-way transportation of a beneficiary from their residence, or another location, to a Medicaid-covered service.
Unloaded Mileage	Mileage traveled when the beneficiary is not in the vehicle.
Volunteer Driver	A transportation provider who utilizes their personal motor vehicle to provide NEMT services to a beneficiary. Volunteer drivers do not have a personal stake or interest in the livelihood of the beneficiary.
Waiting Time	The time that a vehicle is waiting at a Medicaid-enrolled provider's facility in order to transport the beneficiary to another location during the same trip.
Wheelchair Lift Equipped Vehicle	A vehicle owned by a commercial or nonprofit provider that is equipped for a beneficiary who requires a wheelchair and that provides door-to-door service due to their inability to ambulate. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.

SECTION 3 – TRANSPORTATION AUTHORIZATION [CHANGES MADE 4/1/2025]

Medicaid authorizes fee-for-service (FFS) NEMT services via local MDHHS offices, except in Wayne, Oakland, and Macomb counties. FFS transportation services in Wayne, Oakland, and Macomb counties are administered through a contracted transportation broker. (Refer to the Directory Appendix for transportation broker information.)

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all Medicaid covered services. **(revised per bulletin MMP 24-33)** (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP/ICO for further information regarding NEMT. Transportation services for managed care enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

Reimbursement for special allowances requires a completed Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special allowances includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, and other special circumstances supported by medical documentation. **(revised 4/1/2025)** Medicaid FFS authorizing parties may accept the submission of a complete DHS-5330 form via fax and secure email. Transportation providers and beneficiaries may submit original forms if they choose, but sending original forms is not required for authorization. Providers and beneficiaries are encouraged to keep an original or copy of forms submitted to MDHHS for reimbursement.

A DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS-5330 for beneficiaries who do not require special allowances. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services.

An initial verification of medical need for special allowances **(revised 4/1/2025)** is required by the beneficiary's primary care physician (PCP). A completed DHS-5330 signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete a DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary.

In situations when a completed DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the

appointment. Allowable circumstances include, but are not limited to, the beneficiary's first trip to their PCP or medical appointment, or an inability by the beneficiary's physician's office to complete the form and secure the necessary signatures in a timely manner.

Authorizing parties must retain the completed DHS-5330 in the beneficiary's file and make it available upon request. Authorizing parties are responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.

The beneficiary's need for NEMT must be evaluated before services are authorized. This includes assessing all of the following:

- The beneficiary's eligibility;
- The transportation requested is for a service Medicaid covers; and
- The beneficiary has no other means of transportation available. Availability is not dependent on whether the beneficiary previously provided their own transportation.

SECTION 4 – TRANSPORTATION PROVIDER QUALIFICATIONS

All individual and agency transportation providers must adhere to specific qualifications in order to receive Medicaid reimbursement for providing NEMT services. In accordance with the Consolidated Appropriations Act of 2021, a transportation provider who is a beneficiary's family member, or foster parent, or a taxicab driver must meet the following qualifications:

- Provider must not be excluded from participating in any federal health care program.
- Provider must not be listed on the MDHHS sanctioned provider list or U.S. Department of Health and Human Services (HHS) exclusion list.
- Provider must not have been convicted under a federal or state law after August 21, 1996 for a felony criminal offense relating to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

The provider will report any felony conviction relating to a controlled substance or traffic violations. A transportation network company (also known as a rideshare company) and its individual drivers must meet these qualifications in order to provide NEMT services and receive reimbursement by the Medicaid NEMT Contractor, health plan or waiver agency.

Procedures must be in place to document and verify that vehicles used by providers meet the safety needs of the beneficiary including, but not limited to:

- Seatbelts and child safety seat requirements, if appropriate; and
- Functional heating and air conditioning.

NEMT individual and agency providers must consent to required screenings to determine eligibility in order to receive Medicaid reimbursement for providing NEMT services. Individual providers are those persons who provide transportation to a Medicaid beneficiary they are not related to and include, but may not be limited to, volunteer drivers or friends, colleagues, or neighbors of a Medicaid beneficiary. Provider screening is conducted through the CHAMPS provider enrollment process. (Refer to the General Information for Providers chapter of this manual for additional information.)

Beneficiaries who transport themselves or individuals providing NEMT services to a Medicaid-enrolled family member will not be required to enroll in CHAMPS. Self-attestation is sufficient when determining the familial relationship between the driver and the Medicaid beneficiary. Foster parents who transport their foster children are not required to enroll in CHAMPS and are exempt from mandated provider screening requirements.

Public transportation providers (demand response and fixed route) and commercially hailed or street taxicabs are also exempt from CHAMPS enrollment and screening requirements. These providers and their drivers presumptively meet the criteria to provide transportation for Medicaid beneficiaries as they are licensed or registered through the appropriate state authority (e.g., Secretary of State, Licensing and Regulatory Affairs, Michigan Department of Transportation) or equivalent(s) in the state in which they are operating.

4.1 Beneficiaries

The minimum requirements for individuals who transport themselves include:

- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke reimbursement of a provider due to a restricted or suspended license);
- Motor vehicle insurance; and
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used.

Authorizing parties must confirm a beneficiary's eligibility to receive mileage reimbursement through an established process, including but not limited to, documented verbal attestation.

4.2 Volunteer Drivers

The minimum volunteer driver requirements are:

- 18 years of age and older;
- Cannot physically reside in the same household as the beneficiary they are transporting;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.3 Individuals with a Vested Interest

The minimum requirements for individuals with a vested interest are:

- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;

- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.4 Commercial and Nonprofit Providers

The minimum requirements for commercial and nonprofit providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted drivers licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Maintenance of all necessary licensure and certification required by all transportation public laws, ordinances, and regulations applicable to the transportation provider, including any that may require liability insurance;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;
- Compliant with any state or federal statutes applicable to commercial and nonprofit transportation providers;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with the General Information for Providers Chapter of this manual.

NOTE: Taxicab carriers are exempt from CHAMPS enrollment and screening requirements.

4.5 Public Transportation Providers

The minimum requirements for public transportation providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Commercial Driver's License (CDL) if operating a vehicle having a gross vehicle weight of 26,001 pounds or more, or designed to transport 16 or more people (including driver);
- Compliant with Michigan state statutes: Michigan Motor Bus Transportation Act of 1990, as amended; Michigan Motor Carrier Safety Act of 1963, as amended; and Michigan Vehicle Code, as amended;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with the General Information for Providers Chapter of this manual.

NOTE: Public transit services (demand response and fixed route) are exempt from CHAMPS enrollment and screening requirements.

SECTION 5 – USE OF PERSONAL CHOICE AND ACKNOWLEDGEMENT OF PROVIDER SELECTION

A beneficiary receiving transportation services through the NEMT program may select a transportation provider who has been convicted of certain crimes by signing a personal acknowledgement form. The beneficiary must submit their request on the Personal Choice and Acknowledgement of Provider Selection form (MSA-119) that indicates receipt of notification of the criminal offense(s) that prompted the exclusion and must indicate their selection of that provider to deliver services. After the signed acknowledgement is received, processed, and recorded by MDHHS, the effective start date for the selected individual is the date the client signs the MSA-119. The MSA-119 form will be provided by the local MDHHS office. Payment will not be authorized prior to the signature date on the form.

NEMT personal choice selections are subject to the following restrictions:

- The provider does not have a disqualifying conviction that is one of the four exclusions under 42 USC 1320a-7.
- The provider must be capable of providing the required services and must be otherwise qualified to do so.
- The provider has complied with the criminal history screening conducted by MDHHS.
- The provider is not an agency or associated with an agency.

A personal choice selection may be applied for the limited purpose of providing NEMT services to the specific beneficiary identified on the MSA-119. A personal choice selection shall not be construed as approval, authorization or permission to provide services to other beneficiaries. Providers selected through the personal choice provisions of this section must be registered in the Community Health Automated Medicaid Processing System (CHAMPS) and other systems (if applicable) for the purposes of monitoring, contacting, and generating payments.

SECTION 6 – COVERED SERVICES

NEMT expenses, regardless of whether there is a corresponding medical claim on the date of service, may be covered for trips to and from:

- Treatment Medicaid covers (one-time or ongoing);
- Ancillary service providers (e.g., pharmacies, durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] providers) to obtain a service or item Medicaid covers;
- Medical care, treatment or services that have been prior authorized;
- Appointments to obtain medical evidence (for eligibility verification purposes only); and
- Facilities providing services Medicaid covers that do not charge for care.

Transportation from a service Medicaid covers is only covered when it is from the provider's location to the beneficiary's residence or to another service Medicaid covers. The least costly mode of transportation appropriate for the beneficiary's medical needs must be used.

Medicaid authorizes and reimburses transportation providers directly for the following NEMT services:

- Long-term lodging for approved transplant hospitals.
- Transportation to and from pregnancy-related services for Medicaid beneficiaries enrolled in the Maternity Outpatient Medical Services (MOMS) program.
- Transportation to and from day treatment provided by a Community Mental Health Services Program (CMHSP) (as part of its treatment package) for children enrolled in the Children's Waiver Program (CWP).

Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party to receive reimbursement. Medicaid FFS authorizing parties may accept the submission of a complete MSA-4674 form and receipts via fax and secure email. Transportation providers and beneficiaries may submit original forms and receipts if they choose, but sending original forms and receipts is not required for reimbursement. Authorizing parties receiving a completed MSA-4674 may obtain missing information, including signatures, via telephone conversation with the appropriate party. This verification method should only be used to obtain missing information related to a submitted form and not as a method for completing the full MSA-4674. Providers and beneficiaries are encouraged to keep an original or copy of forms and receipts submitted to MDHHS for reimbursement.

NEMT reimbursement must reflect the total incurred cost to the transportation provider(s) and to the beneficiary, and must be verified with itemized, unaltered receipts. All receipts must be legible and included with the MSA-4674. Transportation providers must be enrolled in CHAMPS on the date of service to receive Medicaid NEMT reimbursement unless the provider is exempt from enrollment.

In order to assure appropriate reimbursement for NEMT, MDHHS maintains a database of provider rates which is available on the MDHHS website. The database is reviewed and updated as applicable. (Refer to the Directory Appendix for website information.) NEMT providers must bill MDHHS the usual and

customary fee charged to the public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.

6.1 Mileage

The Medicaid program covers the least-costly available mode of transportation suitable to the beneficiary's medical condition. The following modes of transportation are commonly utilized:

- Commercial and nonprofit transportation
- Fixed route, demand response and deviated route public transportation
- Volunteer drivers
- Individuals with a vested interest
- Beneficiaries providing their own NEMT in their personal vehicle

Volunteer drivers will not be reimbursed for driving a vehicle owned by the beneficiary or a member of the beneficiary's family.

When available, medical providers or entities that offer transportation or medical delivery services at no charge (e.g., prescription delivery services offered by the beneficiary's pharmacy) should be utilized.

Mileage is reimbursed according to transportation provider type at the appropriate rate as indicated on the MDHHS NEMT Database. Total round-trip mileage must be rounded up to the nearest mile and must be verifiable using an online mapping service or a Global Positioning System device.

6.2 Meals

Authorized meals for beneficiaries, volunteer drivers, or individuals with a vested interest are reimbursed at cost or at the maximum allowable amount, whichever is less. To be entitled to meal reimbursement, meals must meet one of the following:

- For breakfast: The vehicle must depart before 6:00 AM and must return after 8:30 AM.
- For lunch: The vehicle must depart before 11:30 AM and must return after 2:00 PM.
- For dinner: The vehicle must depart before 5:30 PM and must return after 8:00 PM.

A vehicle's departure and return times cannot include non-medically related travel including, but not limited to, personal errands or business. Meals are not eligible for reimbursement if they are purchased within the requester's official city of residence.

Meal reimbursement requires itemized, unaltered receipts which must include the business name, address, date, time, and itemized list of items purchased with cost of each item. However, if the restaurant or place of business omits any necessary items from their receipt, the information may be hand-written by the individual incurring that expense.

Bulk purchases of groceries and shared meals are not reimbursable. Meals must be purchased and consumed on the day and within the time of travel. Reimbursement for alcoholic beverages is not permitted. If a lodging reservation or other travel includes a complimentary breakfast or other meals, Medicaid does not provide any additional reimbursement for that meal.

6.3 Fees and Tolls

Travel-related fees and tolls (e.g., parking, toll road, and bridge fare) are reimbursed at actual cost and require original, unaltered receipts. In situations when it is necessary for a Medicaid beneficiary to traverse the Mackinac Bridge and the original, unaltered receipt(s) is unavailable, the authorizing party may still approve reimbursement for the toll when supported by documentation on the MSA-4674. Documentation must include the origin and destination points, and a notation regarding the reason an original receipt is unavailable. This exception is not intended to eliminate the requirement that necessary Mackinac Bridge tolls require original, unaltered receipts and may be subject to post-payment review. Per leg reimbursement for passenger vehicles crossing the Mackinac Bridge will be consistent with rates included on the Mackinac Bridge Authority website.

6.4 Lodging

Medically necessary overnight stays that include meals and lodging may be authorized for a beneficiary and transportation provider for up to 14 consecutive nights. In addition, one medically necessary attendant (or individual with a vested interest) may be authorized if documented by the beneficiary's provider on the DHS-5330. Medically necessary overnight stays beyond 14 nights require prior authorization (PA) from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.)

Medically necessary overnight stays which include meals and lodging at a Level IV Neonatal Intensive Care Unit (NICU) may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's provider on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than 14 nights. Necessary overnight stays at a Level IV NICU beyond 14 nights require PA from PRD.

The least expensive, sufficiently maintained lodging available must be utilized. The availability of nonprofit accommodations (i.e., Ronald McDonald House or accommodations available through the visiting medical facility) must be explored before commercial lodging is considered. Lodging expenses are reimbursed at cost or the maximum allowable amount, whichever is less. Original, itemized, unaltered receipts are required. Reimbursement beyond an accommodation's suggested donation amount or per night rate as charged to the public will not be made.

6.5 Special Allowances

Special allowances (i.e., wheelchair lift-equipped or Medi-Van vehicles, or medically necessary attendants) are reimbursed at the rate listed on the MDHHS NEMT Database. The beneficiary's physician must document the medical necessity of all special allowances on the DHS-5330.

6.5.A. Wheelchair Lift-Equipped Vehicles

Beneficiaries may be eligible for specialized NEMT provided by wheelchair lift equipped vehicles when at least one of the following conditions is met:

- Beneficiary is wheelchair dependent; or
- Beneficiary is medically dependent on life sustaining equipment which cannot be accommodated by standard transportation.

Drivers of wheelchair lift equipped vehicles are expected to assist and escort the beneficiary.

6.5.B. Medi-Van Vehicles

Beneficiaries may be eligible for specialized NEMT provided by Medi-Van vehicles when they require door-to-door or curb-to-curb assistance. Drivers of Medi-Van vehicles are expected to assist and escort the beneficiary.

6.5.C. Medically Necessary Attendants

Beneficiaries may be eligible to receive assistance from one attendant in addition to the driver of a wheelchair lift equipped or Medi-Van vehicle. The attendant must be medically necessary due to the beneficiary's physical, mental, or developmental status. If more than one attendant is needed, prior authorization is required. For additional information, refer to the Prior Authorization (PA) section of this chapter.

6.6 Hospital Facility Meal and Lodging Reimbursement

Some hospital facilities (e.g., University of Michigan Health System [Michigan Medicine]) provide advance expenses for meals or lodging on a per diem basis to Medicaid beneficiaries securing inpatient or outpatient treatment at their facility and their medically necessary attendant (or individual with a vested interest). These facilities seek reimbursement directly from an authorizing party or local MDHHS office after the treatment's end. For these facilities to receive reimbursement of their advance expenses, they must provide to the local MDHHS office, or authorizing party, an invoice or general authorization of services documenting the name of the facility, the name of the Medicaid beneficiary, the date(s) of service, the service(s) requesting reimbursement (i.e., meals or lodging), and the cost of each service. Requests made by the facilities for reimbursement must be received by the local MDHHS office, or authorizing party, within 12 months of the incurred expense. The current maximum per-day rates for these services are indicated on the MDHHS NEMT Database.

SECTION 7 – MANAGED CARE PROGRAMS

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to beneficiaries. These entities are responsible for providing NEMT services to their enrollees for all Medicaid services. (For additional information, refer to the Medicaid Health Plans and the MI Health Link chapters of this manual.)

For services provided to managed care enrollees in an FQHC, the MHP covers NEMT when:

- the service is Medicaid covered and the FQHC is in the MHP's provider network; or
- the MHP has prior authorized the FQHC for the service.

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP or ICO for further information regarding NEMT for their beneficiary. Transportation services for these enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

If a beneficiary was admitted to an inpatient hospital setting prior to the date of enrollment into an MHP or ICO, that entity will not be responsible for the inpatient stay or any travel-related expenses (e.g., miles, meals, or lodging) incurred by the beneficiary or transportation provider until the beneficiary's date of discharge. This includes transportation expenses incurred as a result of the beneficiary's return trip from the hospital to their residence or other outpatient setting. The MHP or ICO will be responsible for all care, including travel expenses, from the date of discharge forward (excluding expenses incurred as result of the beneficiary's return trip to their residence).

For beneficiaries whose MHP or ICO enrollment status has changed, transportation may be authorized and reimbursed retroactively in the following situations:

- The beneficiary's Medicaid eligibility was made retroactive, and the beneficiary received NEMT during the retroactive eligibility time period; or
- Transportation was authorized while enrolled in an MHP or ICO, and then the beneficiary was disenrolled retroactively by the program and enrolled into FFS.

MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services to enrolled Medicaid beneficiaries. Providers must contact the DHP for specific information about covered HKD benefits. (For additional information about HKD, refer to the Dental chapter of this manual.) The MHP is responsible for NEMT to HKD covered dental appointments for their enrollees.

SECTION 8 – PRIOR AUTHORIZATION (PA) [CHANGE MADE 4/1/2025]

Transportation may require PA in certain situations. The PA request must be submitted in writing before the service is provided unless an urgent situation exists and the circumstances are documented. Payment authorization will not be given for PA requests submitted more than 30 days after the service is provided. The PA request, along with the DHS-5330 (when required), **(text added 4/1/2025)** must be submitted to the PRD for review. (Refer to the Directory Appendix for contact information.) Prior authorization may be requested for up to six months for prolonged treatment requiring multiple transports.

Reimbursement for travel expenses related to the following situations requires PA:

- All travel to and from out-of-state/beyond borderland medical providers. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter of this manual for additional information.);
- Transportation reimbursement requests for medical care outside a beneficiary's community when comparable care is available locally;
- Meals and lodging for overnight stays if the medical facility is within 50 miles of the beneficiary's residence;
- Necessary meals and lodging for overnight stays beyond 14 consecutive nights;
- Requests for advance payment of travel costs; and
- Travel expenses for two or more individuals with a vested interest or medically necessary attendants.

The PA request must include:

- Beneficiary name and Medicaid identification number
- Case number
- Beneficiary address
- Explanation of medical necessity of the services requiring PA
- Travel origin and destination
- Effective travel date(s)
- Diagnosis
- Name and telephone number of the individual requesting PA
- Documentation supporting the request

Based on the documentation submitted, the PA request is either approved, denied, or returned for more information. Authorizing parties are informed of the decision in writing, and a copy of the decision must be retained in the beneficiary's file. The authorizing party must then immediately inform the transportation provider and beneficiary of the approval or denial of the PA request. Approval of a PA does not guarantee beneficiary eligibility or payment. It is the authorizing party's responsibility to verify beneficiary eligibility for the date of service prior to NEMT services being rendered.

SECTION 9 – SPECIAL SITUATIONS

9.1 UNLOADED MILEAGE

Unloaded mileage incurred by commercial and nonprofit providers is not reimbursable by the Medicaid program.

9.2 MINORS TRAVELING ALONE

The following travel circumstances apply for minor (under 18 years of age) beneficiaries:

- Children under 12 years of age must be escorted to medically necessary appointments by a parent, foster parent, caregiver or legal guardian.
- For children between the ages of 12 and 18 years, a consent letter signed by a parent, foster parent, caregiver or legal guardian is required for a child to be transported without accompaniment unless access to the service does not require parental consent by the Medicaid program.

The above policy is waived for beneficiaries who have been emancipated or are seeking transportation for health care services for which a minor is legally able to consent (i.e., pregnancy-related, sexually transmitted/venereal disease, HIV/AIDS, substance use disorder, or outpatient CMHSP care).

9.3 MEDICAL REVIEW TEAM APPOINTMENTS

Transportation is a Medicaid-covered benefit and may be authorized for beneficiaries seeking financial or medical assistance due to a disability or blindness. Transportation is limited to one trip for examination and one trip per Disability Determination Services recommendation. A completed DHS-49-F (Medical – Social Questionnaire) serves as documentation and must be retained in the beneficiary's file.

SECTION 10 – REFERRALS

An NEMT referral is not considered a denial of transportation and, as such, a DHS-301 (Medical Transportation Notice) must not be issued when an NEMT referral is made.

The following circumstances are considered referrals:

- Referring a beneficiary to their MHP (for additional information, refer to the Managed Care Programs section of this chapter);
- Referring a beneficiary to the CMHSP; and
- Referring a beneficiary to medical providers who bill Medicaid directly for services (for additional information, refer to the Covered Services section of this chapter).

SECTION 11 – DENIALS AND BENEFICIARY APPEALS

Beneficiaries who have Medicaid coverage have a right to an administrative hearing when services have been denied, reduced, changed or terminated. When a request for NEMT is denied, a beneficiary will be notified with a written denial notice (DHS-301), provided by the authorizing party, which explains the reason for the negative action and informs the beneficiary of their right to appeal. The following requirements must also be met when a beneficiary is denied transportation services:

- The DHS-301 and postage-paid return envelope must be mailed to the beneficiary within one business day of the service being denied;
- A copy of the DHS-301 must be kept in the beneficiary's file and made available upon request; and
- An employee with knowledge of the denial must be available to testify at an administrative hearing, if required.

The beneficiary or beneficiary's authorized representative may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) arranges and conducts the appeal process. Any questions regarding the appeal process should be directed to MOAHR. (Refer to the Directory Appendix for contact information.)

SECTION 12 – NON-COVERED SERVICES

The following transportation services are not reimbursable:

- Waiting time
- Trips that were provided prior to approval from the authorizing party
- Multiple trips for a single Medicaid service
- When a beneficiary failed to keep their appointment
- Trips to and from services that are not covered (e.g., grocery store, non-Medicaid covered medical services)
- Routine medical care outside a beneficiary's community when comparable care is available locally, unless prior authorized
- Transportation to and from services for individuals who have not met their spend-down
- Expenses for services that have already occurred
- Services for long-term care beneficiaries. Routine, non-emergency medical transportation provided for long-term care residents in a van or other non-emergency vehicle is included in the facility's per diem rate. This includes transportation for medical appointments, dialysis, therapies, or other treatments not available in the facility. (Refer to the Nursing Facility Coverages chapter of this manual for additional information regarding NEMT for long-term care beneficiaries.)
- Transportation for managed care program enrollees for services covered under the program contract. (Refer to the Managed Care Programs section of this chapter for additional information.)
- Transportation for services provided in FQHCs
- Transportation for Emergency Services Only beneficiaries
- Transportation for Plan First beneficiaries

NURSING FACILITY

This chapter is comprised of three parts:

The **COVERAGES** portion of the chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

The **CERTIFICATION, SURVEY, & ENFORCEMENT APPENDIX** includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies.

The **COST REPORTING & REIMBURSEMENT APPENDIX** contains Medicaid policy pertaining to nursing facility ownership, reimbursement, costs, and financial reporting.

NURSING FACILITY COVERAGES

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SECTION 1 – GENERAL INFORMATION

This chapter discusses Medicaid nursing facility coverage which is intended to assist beneficiaries in attaining or maintaining the highest practical physical, mental, and psychosocial well-being and maximize independence and decision-making. The chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

Nursing facilities provide services to many of the state's most vulnerable citizens. Medicaid, as the primary payer for beneficiaries who reside in nursing facilities, adheres to all State and Federal regulations that govern care provided in these facilities. Governing regulations include, but are not limited to:

- Americans with Disabilities Act (ADA)
- 42 CFR §431, §438, §440, §441, §448, §483, §485, §488
- State Medicaid Operations Manual
- Medicare Catastrophic Coverage Act of 1988, Public Law 100-360
- Certificate of Need Commission Act 368 of 1978, as amended – Part 222
- Social Security Act
- Omnibus Reconciliation Act of 1987 (Public Law 100-203), 1988, 1989, 1990, and 1994
- Michigan Medicaid State Plan

Only those services covered by the Medicaid Program, as outlined in this chapter, are reimbursable. Included is a full description of:

- Covered Services:
  - Services covered by the facility's per diem rate; and
  - Ancillary services that must be billed separately by the service provider.
- Non-Covered Services that the beneficiary may purchase with their patient-pay amount.

A Medicaid-certified nursing facility is defined as a nursing home, State Veterans' Home, county medical care facility, or hospital long-term care unit with Medicaid certification. Also included are swing beds as defined in the Federal State Operations Manual (SOM) and/or State Medicaid Policy.

Beneficiary is defined as a Medicaid beneficiary, or a person legally sanctioned to make medical decisions on their behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Resident is defined as a nursing facility resident (irrespective of payer source) or a person legally sanctioned to make medical decisions on their behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Individual, as used in this chapter, means any person.

SECTION 2 – MEDICAID HEALTH PLAN

The Medicaid Health Plan (MHP) is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The nursing facility may bill Medicaid after the disenrollment is processed.

Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. If a beneficiary is in a facility prior to enrollment in a health plan and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the health plan and set the NH benefit plan.

SECTION 3 – QUALITY

MDHHS is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that promote and support person-centered planning and quality service delivery.

3.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and their support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.
- Risk and safety concerns are considered and plans developed to minimize risk of harm while promoting independence and safety.
- Behavioral interventions and medication management are used only when necessary and are appropriately managed and monitored.
- Care coordination must support the individual's participation in their care.
- Support for personal responsibility and community relationships that avoid the unintended and detrimental consequences of organizational involvement. Facilities should minimize the disempowerment of beneficiaries or displacement of family members by professional decision-makers and/or service providers, assume the beneficiary is competent and capable of participating in their relationships and the community, and provide assistance and support only when there are unmet needs.
- Individual freedom to exercise civic rights and decision-making authority exists to the maximum extent possible.
- Individuals are free to exercise their due process and grievance rights, and are provided the information necessary to do so.
- Individuals and their support system express satisfaction and the care leads to positive outcomes.
- Diverse cultural and ethnic backgrounds are supported.
- A system of continuous quality improvement that includes input from residents and families.

Current models that utilize person-centered planning and introduce the systems/culture change to support ongoing quality in nursing facilities include, among others, The Eden Alternative™, Wellspring™, and Gentlecare™.

3.2 Quality of Life

Nursing facilities must provide services for residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life. Elements of quality of life include dignity, self-determination, participation in community life and in other activities, participation in resident and family groups, and accommodation of needs through the end of life. Quality of life is defined, measured, and evaluated by residents and their support systems, and may include quality of care outcomes.

3.3 Quality of Care

Nursing facilities must meet the needs of residents in compliance with State and Federal laws, rules, codes, and established clinical guidelines and practices.

Complaints regarding the quality of care in any Michigan nursing facility can be made to the Health Facility Complaint Line. (Refer to the Nursing Facility Section of the Directory Appendix for contact information.)

SECTION 4 – BENEFICIARY RIGHTS

All nursing facility residents have the right to:

- A dignified existence;
- Self-determination; and
- Communication with, and access to, persons and services inside and outside the facility.

In accordance with Federal and State rules and regulations, nursing facilities are required to protect and promote beneficiary rights. These rights include, but are not limited to:

- The right to exercise their rights as citizens of the United States;
- The right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights;
- The right to receive notice of their rights, rules and regulations, both orally and in writing, in a language that the resident understands;
- Access to their medical records and information;

  (In accordance with Federal regulations, a beneficiary [or their representative] must be allowed to inspect their records within 24 hours [excluding weekends and holidays] of such request. Also, in accordance with Michigan Public Health Code, a beneficiary [or their representative] is entitled to receive and examine an explanation of their bill or an itemized statement setting forth services paid for and services rendered, regardless of the source of payment.)
- The right to be informed about their health status;
- The right to refuse treatment;
- The right to non-discrimination, including non-discrimination based on payment source;
- Notification of covered and noncovered services, and any additional costs;
- Notification of any changes in room, policies, physician, health status, and treatment;
- Protection and appropriate management of resident funds;
- The right to covered services;
- Notification of transfer or relocation;
- The right to pain and symptom management at the end of life; and
- The right to re-admission to the nursing facility and to have their bed held during an emergency hospital stay, as defined in the Holding a Bed subsection of this chapter.

In general, beneficiaries cannot be charged for Medicaid-covered services, except for patient-pay amounts, copays or deductibles. This applies to whether they are enrolled as a fee-for-service beneficiary, MDHHS is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or Pre-paid Inpatient Health Plan (PIHP) capitation. However, beneficiaries may be charged if they choose to obtain a service from an out-of-network or non-participating provider, as long as they have prior

knowledge they will be obligated to pay the entire charge and, with that knowledge, they request the service.

Medicaid beneficiaries may not be charged the difference between the provider's charge and the Medicaid payment for a service, nor can they be charged for missed appointments.

Medicaid beneficiaries cannot be charged for the copying of medical records for the purpose of providing them to another health care provider.

SECTION 5 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

5.1 NURSING FACILITY ELIGIBILITY

There are five components that determine beneficiary eligibility and Medicaid nursing facility reimbursement.

- Verification of financial Medicaid eligibility
- PASARR Level I screening
- Physician-written order for nursing facility services
- A determination of medical/functional eligibility based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) prior to or the day of admission to a nursing facility. (Refer to the Nursing Facility Level of Care Determination Chapter for additional information.)
- Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative as described in the Nursing Facility Level of Care Determination Chapter.

These components are defined below.

5.1.A. VERIFICATION OF MEDICAID FINANCIAL ELIGIBILITY

Medicaid reimbursement for nursing facility services for an individual requires a determination of Medicaid financial eligibility for that individual by MDHHS. When a nursing facility enters admission information for an individual who does not have active or pending Medicaid eligibility, a Medicaid Application for Health Care Coverage Patient of Nursing Facility (DHS-4574) will be automatically mailed to the individual.

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by MDHHS.

In order for Medicaid to reimburse for nursing facility services from the date of admission of a Medicaid-eligible beneficiary, the Medicaid beneficiary must be in a Medicaid-certified bed, and the LOCD must be conducted as indicated in the Nursing Facility Level of Care Determination Chapter.

5.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)

The Level I Preadmission Screening/Annual Resident Review (PASARR) must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR] (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification); DCH-3877 is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed (does not trigger a PASARR Level II) by the individual prior to admission.

Placement options for beneficiaries who were determined through Level II Preadmission screening to have a mental illness, intellectual/developmental disability or a related condition are determined through the federal PASARR screening process requirements as to whether or not they need nursing facility services, specialized services, and/or mental health services.

MDHHS performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements. MDHHS reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDHHS is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

5.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician. The physician's degree must appear with the signature. A stamped signature is not acceptable.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid financial eligibility while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid financial eligibility.

5.1.D. Appropriate Placement Based on Michigan Medicaid Nursing Facility Level of Care Determination

5.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination

Financially eligible Medicaid residents must meet medical/functional eligibility for Medicaid reimbursed nursing facility services. To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed, State Veterans' Home) must complete the online LOCD as described in the Nursing Facility Level of Care Determination Chapter.

Change of Ownership (CHOW)

If a new National Provider Identification (NPI) will be issued to a provider who is going through a CHOW, the provider must conduct the hard copy version of the LOCD and Freedom of Choice (FOC). Hard copies of the LOCD and FOC must be conducted in accordance with the policies in the Nursing Facility Level of Care Determination Chapter. Once the provider is given access to CHAMPS under their new NPI, the provider must enter all of the information from the hard copy LOCD into the online version of the LOCD in CHAMPS under their new NPI. The hardcopy LOCDs must be entered in CHAMPS within 30 days of the new NPI's approval date with Provider Enrollment. The records meeting this requirement will have the start date modified to equal the record's conducted date. To ensure proper payments, CHAMPS will then check if the conducted date of the LOCD and enrollment date of the new NPI are within the last six months. Both conditions must be met during a CHOW for CHAMPS to process payments. If the new owner will not be issued a new NPI, the new owner must continue to conduct online LOCDs according to the policies within the Nursing Facility Level of Care Determination Chapter.

5.1.D.2. Retrospective Review and Medicaid Recovery

At random and whenever indicated, the MDHHS designee will perform retrospective reviews of a sample of residents. The purpose is to validate the medical/functional eligibility of the beneficiary. The provider must submit all medical documentation requested by the MDHHS designee. If the resident is found to be ineligible for nursing facility services, MDHHS will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

5.2 Admission Process

Prior to or upon admission, the nursing facility must provide beneficiaries and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with an asterisk (*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *

- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know Your Rights" booklet; *
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered items/services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility's policies to implement advance directives; *
- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or their representative. Individual facilities may develop their own documentation for this process.

5.3 PREADMISSION CONTRACTS

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, their family, or their representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).

SECTION 6 – MEDICAL RECORDS

Nursing facilities are required to maintain a medical record for all residents as outlined in State and Federal statutes and regulations.

Nursing facilities are required to comply with all State and Federal requirements regarding medical record confidentiality, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy.

Nursing facilities must maintain all resident assessments completed within the previous 15 months in the resident's active record. Facilities with a "paperless" system in which clinical records are electronically maintained must be able to produce a paper copy if requested for record review by State surveyors.

Nursing facilities must respect the resident's access to their medical records as required by State and Federal laws and regulations.

SECTION 7 – CARE PLANNING PROCESS

Nursing facility care planning is a continuous and ongoing process of assessment, planning, evaluation, and revision. The purpose of the care planning process is to gather information from a variety of sources, and develop a written strategy to ensure that the resident receives services and supports necessary to attain or maintain the highest practical physical, mental, and psychosocial well-being. Sources of information to support care planning include the resident, their family and friends, physicians, specialists, nurses, nurse aides, dietitians, therapists and assessment tools (including the Minimum Data Set [MDS] for Nursing Facility Resident Assessment and Care Screening). A comprehensive plan identifies and addresses all aspects of the resident's health and well-being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. Using the principles and essential elements of person-centered planning, facilities are expected to involve residents and their designated support system throughout the entire process.

7.1 PERSON-CENTERED PLANNING

Person-centered planning is an ongoing process that recognizes the worth and dignity of each individual and their ability to choose how supports, services and/or treatment may be used to improve their life. The following principles apply:

- **Participation in planning** – Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning their life, with appropriate support if needed.
- **Support for planning** – People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.
- **Outcome orientation** - Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.

Evidence of person-centered planning includes:

- An assessment process that offers the opportunity for gathering information concerning each resident's preferences, personal goals, needs and abilities, health status, and other available supports. This information should be used in developing an individualized plan of care. The individual's life plans should give direction to plans with service providers, such as discharge planning from nursing facilities into community-based settings. Nursing facilities should not exclude residents in the care planning process in order to meet facility requirements for writing care plans, obtaining signatures, and so forth.
- An assessment process that includes input from professionals and others chosen by the individual. In addition to the professionals required to participate in care planning, individuals should have support for making informed choices about the additional people and professionals

they invite to their person-centered planning meetings. For example, federal guidelines require an interdisciplinary team that includes a registered nurse who has responsibility for caring for the resident and prepares care plans. In addition, the resident may choose to invite a favorite nurse aide and a former neighbor/caregiver to participate in care planning.

- A plan of care that comprehensively addresses each individual's need for health care and other services in accordance with the individual's preferences and goals.
- Services delivered in accordance with the individualized plan of care.
- Informed choice, which includes, but is not limited to, choosing among covered services and enrolled service providers, decisions about the planning process, and evaluation of the planning and its outcomes. Informed choice means knowing the options in ways that are meaningful to the individual and having information when it is useful, not only at admission, but throughout the care process.
- Support for informed choice, which requires an organizational commitment to provide information and/or experiences that sufficiently inform an individual of their options. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g., Braille, sign language, audio-recorded documents), hands-on experiences with options, peer support from experienced participants, and so forth.

7.2 Assessment

In collaboration with the resident and individuals identified by the resident, appropriate facility staff must assess residents regularly and as needed to identify their preferences, wishes, goals, outcomes, capabilities, and medical and psychosocial needs. Nursing facilities should use assessment tools that are accessible (e.g., large print, verbal, appropriate language, etc.) to residents and individuals identified by the resident.

Assessment tools must include, but are not limited to, the Minimum Data Set (MDS) for Nursing Facility Resident Assessment and Care Screening. Nursing facilities are expected to use assessment tools and methods that accommodate the needs and preferences of individuals (e.g., mental health assessment tools, self-assessment tools in large print, etc.).

7.3 Minimum Data Set (MDS)

Nursing facilities must conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The use of the current federally specified Resident Assessment Instrument (RAI), which includes the MDS, Care Area Assessment (CAA) process, and utilization guidelines, is mandatory. Michigan has made a determination not to have a state-specific Section-S, but reserves the right to develop and require its data collection as need arises.

The MDS assessment must be conducted:

- Promptly upon admission, but no later than 14 days of admission;
- Promptly after a significant change in the resident's physical or mental condition or within two weeks, whichever is sooner; and
- Not less than once every twelve months.

The facility must examine each resident once every three months, revising the assessment as appropriate to ensure its continuing accuracy.

Results of the MDS assessment must be used, in addition to other information gathered and in collaboration with the resident, for developing, reviewing, and revising the resident's plan of care. The assessment must be maintained in the resident's medical record and kept confidential.

NOTE: The Michigan Medicaid MI Choice Waiver Agencies are the designated Local Contact Agency (LCA) relative to Section Q of the MDS. (Refer to the Directory Appendix for contact information.)

Each MDS assessment must be conducted or coordinated (with the appropriate participation of other health professionals) by a licensed, registered nurse who signs and certifies the completion of the assessment. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion. Data accuracy resides with the nursing facility as the source of the data.

A facility must electronically transmit to the State, at least monthly, encoded, accurate, complete MDS data for all assessments conducted since the previous transmission. A facility that fails to transmit electronic RAI data to the State is considered out of compliance and, therefore, subject to enforcement actions. (Refer to the Nursing Facility Certification, Survey and Enforcement Appendix of this chapter.)

An individual who willfully and knowingly certifies a material and false statement, or causes another individual to do so, is subject to a civil money penalty.

Questions about the Resident Assessment Instrument should be directed to the Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification, RAI Coordinator. (Refer to the Directory Appendix for contact information.)

Federal regulations require that facilities coordinate the PASARR process and MDS. MDHHS recommends that nursing facility administrators establish mechanisms to track completion dates of PAS and ARR evaluations so that, to the maximum extent practicable, they are coordinated with resident assessments and completion of the MDS.

7.4 Preadmission Screening/Annual Resident Review (PASARR)

The Preadmission Screening and Annual Resident Review (PASARR) must be completed for all individuals seeking to enter a nursing facility regardless of payer source. Although not federally mandated, Michigan has elected to require the Annual Resident Review (ARR) for all residents in Medicaid-certified nursing facilities regardless of payer source.

The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Intellectual/Developmental Disability (I/DD) or a related condition in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or an intellectual/developmental disability or having a related condition, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.

Screening and evaluations performed under PASARR and all PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

(Refer to the PASARR Process section of this chapter for additional information.)

7.5 Plan of Care

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or their representative;
- The attending physician;
- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care;
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.

7.6 Evaluation/Re-assessment/Plan Revision

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or their representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.

SECTION 8 – PASARR PROCESS

Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The Level I screening and Level II evaluation procedures and forms are the same for Pre-admission Screening (PAS) and Annual Resident Review (ARR). The forms may be obtained from the MDHHS website.

The PASARR process must be completed:

- Prior to admission to a nursing facility;
- Promptly after a significant change in a resident's physical or mental condition; and
- Not less than annually.

The PASARR process is not required in the following situations:

- When an individual is admitted to and resides in a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- When an individual is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.
- For an individual transferring from one nursing facility to another, with or without an intervening hospital stay, unless a Level I screen has not been performed previously. If a Level I screening or Level II evaluation has been completed, the screening evaluation should accompany the beneficiary to the receiving nursing facility.
- For an individual returning to the nursing facility from therapeutic leave, unless the resident's condition has changed. Therapeutic leave does not change the due date for Annual Resident Review. Advance planning may be necessary to ensure timeliness of review.
- A beneficiary receiving Medicaid hospice services (Benefit Plan ID of Hospice) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period.

  The purpose of the Level I screening is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on psychotropic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) to better evaluate the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the CMHSP will determine the need for Level II screening.
- An individual assessed by adult protective services, requiring protective services, may be granted provisional admission to a nursing facility pending further assessment due to this emergent situation. Placement in a nursing facility is not to exceed seven (7) days.

The following table outlines screening requirements.

Pre-Admission Screening (PAS)	A Level I screening is required for all individuals seeking to enter a nursing facility regardless of payer source, except as noted above. The Level I screening, and the Level II evaluation when indicated, must be completed prior to admission to a nursing facility.
Annual Resident Review (ARR)	All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care. Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review. The Level I screening must be completed for all residents, and a Level II evaluation must be performed if indicated. If a resident was hospitalized when an ARR was due, the Level I screening must be completed within 30 days of readmission, and any subsequent Level II evaluation must be completed within the quarter following readmission to the nursing facility.
Change in Condition	A Level I screening must be completed immediately or, at most, within 14 days when there is a significant change in the resident's mental health, or a physical change that may impact the resident's mental health needs. Federal regulations define a "significant change" as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. Changes to the Minimum Data Set (MDS), Section E (indicators of depression, anxiety, mood) would indicate a significant change for PASARR purposes. A change in condition would also be done if the consumer is in a facility in any state other than Michigan and transfers into a Michigan nursing facility. This should be done as soon as the consumer arrives at the Michigan nursing facility, no later than the 14th day after arrival. The nursing facility must notify their local CMHSP via a DCH-3877 for a Level II evaluation.
30-Month Rule	During the PASARR process, a nursing facility resident may be identified as no longer in need of nursing services but in need of specialized services. In this situation, if the resident has lived in a nursing facility for 30 continuous months, the CMHSP must advise the individual of their options, which may include community placement with specialized services or continued residence in the nursing facility with specialized services. Under these circumstances, no appeal needs to be filed in order to maintain nursing facility residency. The individual's status as a long-term resident must be evident in their nursing facility medical record. Individuals determined to need specialized services, who have resided in a nursing facility for less than 30 months, and who are found to no longer need nursing services must be assisted to transition to a more appropriate setting.
Borton vs. CalifonoTransfer Trauma	Transfer trauma protections apply to individuals with mental illness, intellectual/developmental disability or a related condition who were determined during a PASARR Level II evaluation to not need nursing facility services. Transfer Trauma is defined as any adverse psychological and/or physical effects occasioned by the transfer of a nursing facility patient that would be materially detrimental to the physical or mental health of the patient.

8.1 Level I Screening

The purpose of the Level I Screening is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification)" form (DCH-3877). (Refer to the Forms Appendix for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

The professional who completes the Level I Screening must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (For the distribution of forms and documentation, refer to the Distribution of PASARR Documentation subsection later in this section.)

The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of anti-depressant and psychotropic medications, defined as any drug that affects brain activities associated with mental processes and behavior.

The list is not meant to be all-inclusive.

Anti-Depressant Medications	
Generic Name	**Brand Name**
Amitriptyline Hydrochloride	Elavil
Bupropion Hydrochloride	Wellbutrin
Citalopam	Celexa
Doxepin Hydrochloride	Sinequan
Fluoxetine Hydrochloride	Prozac
Fluroxamine	Luvox
Imipramine Hydrochloride	Tofranil
Mirtazapine	Remeron
Netazodone Hydrochloride	Serzone
Nortiptyline Hydrochloride	Aventyl, Pamelor
Paroxitine	Paxil
Sertraline Hydrochloride	Zoloft
Trazodone Hydrochloride	Desyrel
Venlafaxine Hydrochloride	Effexor

Psychotropic Medications	
Generic Name	**Brand Name**
Chlorpromazine Hydrochloride	Thorazine
Clozapine	Clozaril
Fluphenazine Hydrochloride	Prolixin
Haloperidol	Haldol
Loxapine Hydrochloride	Loxitane
Mesorldazine Besylate	Serentil
Olanzapine	Zyprexa
Quetiapine Fumarate	Seroquel
Risperidone	Risperdal
Thioridazine Hydrochloride	Mellaril
Thiothixene	Navane
Trifluoperazine Hydrochloride	Stelazine
Ziprasidone	Geodon

Miscellaneous Products	
Generic Name	**Brand Name**
Lithium Citrate	Cibalith-S
Lithium Carbonate	Eskalith, Lithobid

8.2 Level II Evaluation

The purpose of the Level II evaluation is to assess individuals who are identified as having a mental illness, intellectual/developmental disability or a related condition to determine the need for nursing facility services, specialized services, and/or mental health services. All individuals identified by Level I screening as possibly having a mental illness, intellectual/developmental disability or a related condition (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation unless it is documented that they meet one of the exemption criteria outlined in the next subsection, or the MDHHS/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. The CMHSP is responsible for providing the nursing facility and the individual and/or legal representative with written documentation that the individual does not meet the PASARR criteria for a serious mental illness. If the individual is seeking admission to a nursing facility, the Level II evaluation, when indicated, must be completed prior to admission.

8.3 Level II Evaluation Exemption

If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix for a sample form.) The DCH-3878 must be completed, signed, and dated by a physician's assistant, nurse practitioner, or a physician.

Exemptions to the Level II evaluation may be requested based on the following criteria:

- The individual is in a coma. If the individual is in a coma at the time the Level II evaluation is to be performed, the individual may be exempted from the Level II evaluation process. A physician must certify that the individual is in a coma. The individual may then be admitted to the nursing facility without a Level II evaluation. When the individual is no longer in a coma, the nursing facility must complete a Level I screening and refer for a Level II evaluation, if indicated.
- The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as having an intellectual/developmental disability or a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual diagnosed with dementia and a primary diagnosis of depression may not be exempted. A physician's assistant, nurse practitioner or physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, intellectual/developmental disability, or a related condition.
- The individual is convalescing after hospitalization for an acute illness and meets all of the following conditions:
  - The individual will be admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital. Treatment in an emergency room is not considered a hospital stay. An individual who received inpatient treatment in a

psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement (i.e., Adult Foster Care [AFC] and assisted living).

- The individual requires nursing facility services for the condition for which they received care in the hospital.
- The attending physician, physician's assistant, or nurse practitioner has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.

Medicaid approves payment for a hospital discharge/convalescent care stay up to 30 days only. If the individual needs nursing care beyond 30 days, the nursing facility must notify the local CMHSP at least five working days before the end of the 30-day stay that a Level II evaluation is needed. The local CMHSP completes the Level II evaluation within 14 days of the date of notification and forwards the evaluation to MDHHS. The entire determination process must be completed within 40 days of the individual's admission from the hospital. If MDHHS determines that the individual no longer requires nursing facility services, Medicaid reimburses up to five days beyond the date of the determination to allow for appropriate discharge planning. It is expected that a nursing facility will begin discharge planning for residents at the time of admission from the hospital and discontinue this planning only when a determination is made that the resident will not be discharged from the nursing facility.

The person completing the Level II evaluation exemption must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

8.4 Level II Evaluation Completion

Individuals who are identified at the Level I screening as having a mental illness or intellectual/developmental disability or a related condition, and who do not meet exemption criteria outlined previously, must be referred to the local CMHSP for a Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP under contract with MDHHS. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDHHS OBRA Operations Manual. A copy of this manual may be requested from the MDHHS OBRA Office or the local CMHSP.

When a Level II Evaluation is required, it must be completed prior to nursing facility admission.

When a Level II evaluation is indicated for an Annual Resident Review (ARR), the nursing facility must notify the local CMHSP of the need for the Level II evaluation at least 30 days prior to the due date of the ARR by sending them a new DCH-3877 (Level I screening form). For example, if the initial Level II evaluation was completed on April 15, 2004, the ARR is due April 15, 2005, and the facility must notify the local CMHSP that a new Level II is due by March 15, 2005. The local CMHSP is responsible for timely completion of Level II evaluations and for providing facilities with written documentation of PASARR determinations in a timely manner.

Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDHHS. Based on this documentation, MDHHS determines whether the individual requires nursing facility services or can be served in an alternate setting. MDHHS also determines whether specialized services or other mental health services are needed to treat the individual's mental illness, intellectual/developmental disability or a related condition.

The MDHHS decision regarding the need for nursing facility services and the need for specialized services is forwarded to the referring CMHSP. It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and their legal representative. The CMHSP must provide a copy of the evaluation and the MDHHS determination letter to the individual and their legal representative and explain the appeal rights to the individual and their legal representative. This information must also be adapted to the cultural background, language, ethnic origin and means of communication of the individual being evaluated.

The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDHHS determination in writing within five (5) days of the review. A copy of this notification must be retained in the individual's record. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

If the facility does not receive a written determination as follow-up to a verbal determination within 30 days of an admission, the facility must send a written reminder to the CMHSP and the MDHHS OBRA Office within 45 days of the admission. (Refer to the Directory Appendix for contact information.)

The nursing facility is responsible for verifying that required PAS and ARR processes are completed and documented in the resident's record. The nursing facility medical record must include the determinations of the level of care, the need for specialized services, the original DCH-3877 and DCH-3878 forms, and the Level II evaluation report and supporting documents.

8.5 Distribution of PASARR Documentation

The following chart shows the correct distribution of copies of PASARR forms (DCH-3877, DCH-3878) and Level II evaluation documentation. All originals must be fully completed and signed.

Level I Screening Documentation (DCH-3877)		
Original	Nursing facility record	All nursing facility admissions
Copy	Individual or their legal representative	All nursing facility admissions
Copy	CMHSP	If "yes" answer(s)
Copy	MDHHS via local CMHSP	If "yes" answer(s) and no exemption criteria met

Documentation of Exemption to Level II Evaluation (DCH-3878)	
Original	Nursing facility record
Copy	Individual or their legal representative
Copy	CMHSP
Copy	MDHHS via local CMHSP

Level II Evaluation Documentation	
Electronic Record	MDHHS OBRA Office
Copy	CMHSP
Copy	Individual or their legal representative
Copy	Nursing facility
Copy	Hospital, attending physician

MDHHS Determination	
Electronic Record	MDHHS OBRA Office
Copy	CMHSP
Copy	Individual or their legal representative
Copy	Hospital, attending physician
Copy	Nursing facility

8.6 Compliance

Failure of a nursing facility to comply with OBRA PASARR requirements will result in the loss of Medicaid reimbursement to the facility for services provided for that resident for any period during which a correct and timely screening or review was not completed for that resident. A claim should not be submitted for dates of services provided during periods for which required Pre-admission Screening or Annual Resident Review has not been completed.

The resident or parties responsible for the resident cannot be charged for the loss of reimbursement caused by the facility's failure to meet PASARR requirements.

The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed, and dated with appropriate credentials noted, and distributed. The Level II evaluation process is completed when the CMHSP has completed the evaluation and the individual has been notified of the MDHHS determination.

For a screening or evaluation to be correct, the completed forms must contain information consistent with documentation in the resident's nursing facility medical record.

Compliance is monitored through the survey process, complaint investigations, and audits. Retrospective payment adjustments through interim gross adjustments and/or final settlements are made to recover funds as necessary. A nursing facility is not penalized for failures to meet PASARR provisions for which it is not responsible and/or could not prevent.

8.7 Appeals of PASARR Determinations

Individuals adversely affected by PASARR determinations may appeal the determination or another person may appeal the determination on their behalf. Examples may include the determination that the individual no longer requires specialized services when they have received those services in the past and

wish to continue. An individual may decline nursing facility admission or specialized services without appeal.

Information regarding the MDHHS administrative hearing (appeal) process is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

8.8 Complaints

Complaints or concerns regarding a nursing facility's implementation of the PASARR regulations should be directed to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

Complaints or concerns about local CMHSP implementation of PASARR policy should be sent to the MDHHS OBRA Office. (Refer to the Directory Appendix for contact information.)

SECTION 9 – MEDICAID COVERED AND NON-COVERED SERVICES

Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (MD or DO) and is subject to MDHHS review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.

9.1 MEDICARE-COVERED SERVICES

For Medicare Part B covered services, MDHHS only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles) or the Medicaid fee screen, whichever is less. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.

Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).

If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or PIHP capitation, the PIHP/CMHSP assumes the MDHHS payment liability described in this section.

For Medicare coinsurance days billed to Medicaid, the beneficiary may be in either a Medicare certified or Medicare/Medicaid dually certified bed.

Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

9.2 MEDICARE DENIAL OF BASIC CARE

Medicare covers only skilled care. Medicaid covers both basic and skilled care. In the event a dually eligible Medicare/Medicaid beneficiary requires basic care, Medicaid will cover the service if all other admission criteria are met (e.g., physician order for nursing facility care and beneficiary meets the Medicaid Nursing Facility LOC Determination for NF care).

9.3 Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay

A dually eligible beneficiary who resides in a Medicaid-only certified bed and is admitted to a hospital for acute care services may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits at the time of hospital discharge. If that beneficiary wants to return to the Medicaid NF bed they originally occupied, they may refuse their Medicare SNF benefit and Medicaid will reimburse for all medically necessary nursing facility days and other medically necessary services. The days billed to Medicaid must be included in the Medicaid census statistics.

The nursing facility must advise beneficiaries of their right to refuse their Medicare SNF benefit in order to return to their Medicaid NF bed. This notice must be in a manner that the beneficiary, family member, or beneficiary's legal representative can understand or have clearly explained to them as needed.

9.3.A. Required Documentation

The facility must maintain, in the beneficiary's clinical and fiscal record, documentation that supports the beneficiary made the choice to forego Medicare-reimbursed services and return to their Medicaid-only certified bed. This documentation must be signed and dated by the beneficiary (or their authorized representative) and a nursing facility representative.

9.3.B. Medicare Part B

Required outpatient physical or occupational therapy, or outpatient speech pathology for NF beneficiaries must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

9.4 Other Insurance

Many Medicaid beneficiaries have insurance coverage (either traditional health insurance or an HMO) through private and/or employer-based commercial policies. That insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, prior authorization requirements, qualifications of providers, and providing services through the insurer's provider network. MDHHS does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

MDHHS pays appropriate copays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDHHS cannot be billed more than the negotiated rate. Medicaid-covered services not included in the primary insurer's plan are reimbursed by MDHHS up to the Medicaid fee screen if all MDHHS coverage rules are followed. If a beneficiary with other insurance coverage is enrolled in a MHP or is receiving services under CMHSP or PIHP capitation, the MHP/PIHP/CMHSP assumes the MDHHS payment liabilities described in this section.

9.5 Payment for Non-covered Services

For necessary medical or remedial care recognized under State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. The services would include services rendered by providers not enrolled in the Medicaid program. The offset to the patient-pay amount must be reported for the month that services were provided. If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

SECTION 10 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility's per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

The nursing facility should contact the ancillary provider or Medicaid Provider Inquiry Line to confirm Medicaid coverage of ancillary services.

All services required as a condition of licensure/certification are included in the per diem rate.

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Administrative Services	X		
Admission Kits (Limited to routine personal hygiene items (See Personal Hygiene Items description)	X		
Alcohol Abuse Treatment (See Substance Abuse Services and Treatment description)		X	
Ambulance Services – Emergency and non-Emergency (See Transportation description)		X	
Ancillary Services			X (some)
Beauty and Barber Services			X
Chiropractic Services		X	
Daily Oral Hygiene and Supplies (See Dental Services description)	X		
Dental Services		X	
Dietary Services and Food (including enteral tube feeding formula, supplies and equipment)	X		
Drug Dependency Treatment (See Substance Abuse Services and Treatment description)		X	
Dry Cleaning (See Laundry Services description)			X
Durable Medical Equipment – customized equipment		X	
Durable Medical Equipment – standard equipment	X		
End of Life Care	X		
Enrichment Programs	X		
Family Planning Services		X	
Food (See Dietary Services and Food description)	X		

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Foot Care – Routine (See Podiatry Services description)	X		
Hearing Services		X	
Hospice Services – Nursing Facility Responsibility	X		
Hospice Services – Hospice Responsibility		X	
Hospital Services (Inpatient and Outpatient)		X	
Housekeeping and Maintenance	X		
Intravenous Therapy – nursing supplies, equipment (including all pumps)	X		
Intravenous Therapy – pharmaceuticals		X	
Laboratory Services – routine	X		
Laboratory Services Requiring Special Laboratory and Professional Laboratory Staff		X	
Laundry Services	X		
Medically-Related Social Services	X		
Medication Reviews (See Pharmacy description)	X		
Mental Health Services – facility provided	X		
Mental Health Services – local CMHSP and referrals		X	
Nurse Aide Attendance for Medical Appointments (See Transportation description)	X		
Nursing Care – routine	X		
Orthotics		X	
Oxygen - intermittent and infrequent	X		
Oxygen – daily use		X	
Personal Comfort Items			X
Personal Hygiene Items	X		
Pharmacy – Medicaid Covered Over-the-Counter Drugs		X	
Pharmacy – Routine Over-the-Counter Drugs	X		
Pharmacy— Prescription Drugs		X	
Physician Services		X	
Podiatry Services		X	
Private Duty Nursing in a Nursing Facility			X
Private Room (if medically necessary)	X		
Private Room (no medical necessity)			X

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Prosthetics		X	
Radiology		X	
Supplies and Accessories	X		
Therapies – Routine maintenance	X		
Therapies – Non-routine		X	
Total Parenteral Nutritional Formula, Equipment and Supplies (See Dietary Services and Food description)		X	
Transportation Services - non-emergency	X		
Vaccines	X		
Vision Services		X	
Wound Dressings (see Supplies and Accessories)	X	X (some)	

10.1 Administrative Services

Nursing facilities must be administered in a manner that effectively and efficiently uses its resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in compliance with all applicable State and Federal licensure and certification laws, codes and regulations. Services rendered in the general administration of the facility are included in the facility's per diem rate. Services include, but are not limited to:

- Arranging appointments;
- Building, equipment, and grounds maintenance;
- Development, adoption, and posting of patient rights;
- Development of disaster plans;
- Development of patient councils;
- Infection control;
- Insect and vermin control;
- Management of patient trust funds;
- Nursing care determinations;
- Quality control;
- Record keeping; and
- Utilization control.

10.2 Admission Kits

Routine personal hygiene items in an admission kit are included in the per diem rate. Nonroutine personal hygiene items in an admission kit are not reimbursable and are not allowable costs.

10.3 Ancillary Services

Ancillary services (i.e., services other than daily care services), excluding physician services, must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix for contact information.)

The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.

Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.

Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.

10.4 Beauty and Barber Services

Any services of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program. The beneficiary may purchase such services from personal funds. A beneficiary's patient-pay amount may not be used to cover these costs.

10.5 Chiropractic Services (Medically-necessary)

Chiropractic services, such as x-rays and treatment, are an ancillary service and are not included in the facility's per diem rate.

10.6 Dental Services

The facility's per diem rate includes providing assistance with, and supplies for, daily oral hygiene. Dental supplies include, but are not limited to:

- Dental floss
- Mouthwash
- Mouthwash cups
- Denture adhesive
- Denture cleaner
- Denture cups
- Toothbrushes
- Toothpaste

Routine and emergency dental services are an ancillary service and are not included in the facility's per diem rate.

10.7 Dietary Services and Food

Residents must be provided nourishing, palatable, well-balanced meals that meet their daily nutrition and special dietary needs. Dietary services must also meet the preferences of residents and offer substitutes of similar nutritional value.

Nutrition appropriate for each resident's condition is included in the facility's per diem rate. This includes, but is not limited to:

- Daily nutritious meals and snacks
- Reasonable food substitutes of a similar nutritive value
- Dietary supplements
- Enteral formulas, supplies, equipment, and associated nursing services
- Infant formulas
- Nursing services associated with total parenteral nutrition (TPN) *
- Special diets
- Therapeutic diets
- Water solutions

Medicaid reimburses non-profit nursing facilities that incur costs resulting from the purchase of raw food and food preparation associated with special dietary needs for religious reasons. (Refer to the Cost Reporting and Reimbursement Appendix of this chapter for more information.)

* The formula, equipment, and supplies required for the TPN feedings are an ancillary service and are not included in the facility's per diem rate.

10.8 Durable Medical Equipment

10.8.A. Standard Equipment

Standard durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

- Adaptive Activities of Daily Living (ADL) equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes
- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Footboards
- Footrails
- Footstools
- Freestanding trays for meals
- Geriatric chairs
- Infrared lamps
- Lap and half-lap trays
- Lifts
- Oxygen equipment and supplies
- Pads, water-circulating devices to apply heat or cold therapy (e.g., hot/cold packs, heating pads)
- Positioning pillows
- Pressure-relief positioning cushions
- Reading lights
- Sitz baths
- Splints
- Standard manual wheelchairs
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Wheelchairs for transport in or out of the facility

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, their family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

Medicaid policy has historically established that standard wheelchairs and other specified durable medical equipment are included in the Medicaid facility per diem rate in accordance with federal standards and state licensure requirements. The following describes what is meant by standard wheelchairs relative to current types of wheelchair products that are routinely prescribed and commonly available in the marketplace, and routinely prescribed and required for patient use in the long-term care environment.

In addition, nursing services include positioning and body alignment and preventive skin care. The nursing facility is responsible for proper pressure relief and positioning. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Standard manual wheelchairs are included in the facility's Medicaid per diem rate. A standard manual wheelchair is any wheelchair that is routinely prescribed and required for patient use in the long-term care environment. Standard manual wheelchairs that must be available to meet health and care standards include wheelchairs and accessories that are manufactured stock items, including heavy-duty, light- or ultra-light -weight and/or -strength; hemi chairs; wheelchairs with adjustable or reclining backs; manual tilt-in-space; removable/adjustable arms; variable seat height, width or depth; anti-thrust seats; laterals, abductors, and adductors; or other non-custom positioning options. In addition, pressure-relief positioning cushions, positioning pillows, trochanter rolls, etc. required for proper beneficiary use of the wheelchair or the provision of nursing services are the responsibility of the facility.

10.8.B. Custom-Fabricated Seating and/or Power Wheelchairs

Custom-fabricated seating and/or power wheelchairs for nursing facility residents may be covered when the established standards of coverage are met and the severity and intensity of the disease process requires custom-fabricated seating or a power-operated wheelchair as medically necessary and is an integral part of the facility's daily nursing plan of care.

Repairs to custom-fabricated equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.

10.8.B.1. Medical Necessity

A physician's order by itself is not sufficient documentation of medical necessity, even when it is signed by the treating physician. Clinical documentation from the medical record must support the medical necessity for the request and substantiate the physician's order. In addition, Medicaid coverage is not based solely on a physician's order; the request must also meet the standards of coverage published by MDHHS. (Refer to the Medical Necessity subsection of the Medical Supplier chapter for a complete description of medical necessity requirements.)

The nursing facility's responsibility for each resident's health care needs and other services, including patient care, transfers, safety, skin care, equipment, medical supplies, etc., are described in federal regulations and state licensure requirements. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Refer to the Medical Supplier chapter for additional information regarding Medicaid definitions and standards of coverage for mobility and custom-fabricated seating systems.

10.8.B.2. Noncovered

Power wheelchairs and custom-fabricated seating systems, including add-on components, are not covered outside the facility per diem rate when:

- There is an appropriate economic alternative.
- The devices are not related to, or an integral part of, the nursing facility daily plan of care.
- The accessory or add-on component is deemed to be standard under the definition of a standard manual wheelchair.
- The wheelchair is used as a restraint or for the purpose of treating aberrant behaviors.
- The need for the wheelchair is a substitute for appropriate clinical nursing services, as defined in federal regulations.
- The wheelchair is inappropriate for the beneficiary's cognitive level or behavioral level.
- The beneficiary is unable to safely operate the wheelchair.
- A standard wheelchair meets functional need or outcome as defined in the plan of care.
- The device is ordered for nonstandard use (e.g., therapeutic modality or exercise).
- The device is ordered to increase sitting tolerance that exceeds acceptable medical guidelines for skin care and pressure.

10.8.C. Prior Authorization

Prior authorization is required for Medicaid coverage of medically-necessary power wheelchairs, custom-fabricated seating, and manual wheelchairs with custom-fabricated seating systems outside of the facility per diem rate. The treating physician must initiate

the referral for custom-fabricated seating or a power-operated vehicle (POV) based on an identified medical need in the plan of care. Facility clinicians who are responsible for the overall nursing plan of care for, and treatment of, the resident prepare and submit prior authorization requests, medical documentation, and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) within 90 days of the date the evaluation was completed. (Refer to the Prior Authorization subsection of the Medical Supplier chapter for additional information, and to the Forms Appendix for a copy of the form and form completion instructions.)

10.9 End of Life Care

Facilities are expected to have systems and policies in place to address appropriate advance care planning and end of life care. Facilities must notify residents at admission of their policies regarding the implementation of advance directives and the availability of hospice care. Residents are entitled to adequate and appropriate pain and symptom management as a basic and essential part of their medical treatment.

10.10 Enrichment Programs

Facilities are required to provide or arrange for an ongoing program of activities designed to meet the interests and physical, mental and social well-being of each resident. An individualized program may be developed as part of the person-centered care planning process. Programs designed to maintain the resident's quality of life are included in the facility's per diem rate. Such services include, but are not limited to:

- Social services;
- Books;
- Current periodicals (e.g., newspapers, magazines) [If the beneficiary personally subscribes to a periodical (e.g., newspaper, magazine) for their own use, they are responsible for payment of that subscription.];
- Diversional programs;
- Motivational programs;
- Reality-oriented programs; and
- Recreational programs.

10.11 Family Planning Services

Family planning services are an ancillary service and are not included in the facility's per diem rate.

10.12 Hearing Services

Hearing evaluations are an ancillary service and are not included in the facility's per diem rate.

A Medicaid copayment is not required for nursing facility beneficiaries.

10.13 Hospice Services

Upon admission to a nursing facility, residents must be advised of the facility's policies regarding the availability of hospice care.

Nursing facility beneficiaries (including Medicaid-approved complex care cases) are eligible for Medicaid hospice services if determined by a hospice provider to meet hospice level of care. Additionally, in certain situations (such as lack of a caregiver in the home), a hospice beneficiary, in consultation with the hospice provider, may elect to enter a nursing facility to receive end of life care. Medicare beneficiaries receiving or eligible for the 100-day skilled nursing benefit have the right to choose hospice instead. This decision should not be influenced by differences between hospice and Medicare skilled nursing facility reimbursement rates.

If the beneficiary is enrolled in a MHP and is admitted to the nursing facility with the hospice benefit, the MHP is responsible for reimbursement of hospice services.

For nursing facilities that elect to contract with hospice providers, a written contract is required between the hospice provider and the nursing facility that specifically outlines the responsibilities of each. Additionally, the contract must specify how the hospice provider will reimburse the nursing facility for room and board.

Nursing facilities **cannot** bill Medicaid directly for room and board or any other services for hospice beneficiaries. A hospice is responsible for all costs for a person receiving hospice care. The hospice bills Medicaid for room and board, then reimburses the nursing facility at the rate specified in the contract between the providers.

MDHHS reimburses the hospice for its daily rate, for room and board, and QAS for beneficiaries in Medicaid or Medicaid/Medicare dually certified beds. The room and board rate is 95% of the facility's Medicaid per diem rate, plus 100% of the QAS amount. Although the rate paid to the hospice by Medicaid is set, it is not necessarily the rate that the hospice must pay the facility. It is expected that some services may be purchased or traded between the facility and the hospice, so the negotiated room and board rate must be stipulated in the contract.

Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another as long as services were provided by both agencies. (This will be randomly verified by post payment audit and as indicated.) If the beneficiary has hospice as of 12:01 a.m., the hospice is responsible for the payment of services provided to the beneficiary until midnight. The hospice will continue, for payment purposes, as the primary provider for the full day of discharge.

Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge only if the discharge is due to resident death. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered as the resident is not there at the midnight census to be counted as a resident.

Because Medicaid is making a payment for room and board (even though it is paid to the hospice), beneficiaries must be treated as all other Medicaid beneficiaries. For example, the facility cannot seek or accept additional or supplemental payment from the beneficiary, their family, or representative in addition to the amount paid for the covered service, even when a beneficiary has signed an agreement to do so.

10.13.A. Nursing Facility Responsibilities

Nursing facilities must adhere to all State licensure requirements, even though some of the components of care are provided by the hospice rather than the nursing facility. An example of a licensure component completed by the hospice is that, upon admission, the hospice provides the facility with copies of the beneficiary's history and physical, interdisciplinary assessment, and plan of care. For purposes of licensure, these copies are accepted as appropriate.

If a beneficiary is already receiving hospice services and elects admission to a nursing facility, it is the responsibility of the hospice provider to update the beneficiary's location of service in CHAMPS. To update the beneficiary's location of service in CHAMPS, the hospice provider must discharge the beneficiary and complete an admission with the updated location of service in CHAMPS. (Refer to the Beneficiary Admission and the Beneficiary Discharge sections of the Hospice chapter for additional information.) The new admission will result in real-time changes to the beneficiary's Program Enrollment Type (e.g., HOS-NFAC) and the National Provider Identification (NPI).

Hospice staff cannot be utilized to meet staffing patterns required for licensure (i.e., the facility cannot include hospice staff on staffing reports).

Although the hospice is responsible for developing the coordinated plan of care, the nursing facility, as well as the beneficiary, must be an active participant in its development.

If the hospice beneficiary in a nursing facility has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Services that must be provided by the nursing facility include:

- Room and board;
- Laundry (including facility items as well as personal items); and
- All other non-terminal illness-related services afforded other Medicaid beneficiaries (e.g., services included in the per diem rate).

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Facilities must offer the same drugs, services, medical supplies and equipment to all beneficiaries who have elected the hospice benefit in the same manner that services are provided to other beneficiaries in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem rate, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

10.13.B. Hospice Responsibilities

Hospice must certify/re-certify the beneficiary's need for hospice care.

If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to admit the beneficiary for hospice services, indicating the nursing facility NPI in the Admission Information Section in CHAMPS. A completed admission will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET code. (Refer to the Beneficiary Eligibility chapter for additional information.)

The hospice, in collaboration with the beneficiary and/or family and nursing facility, will establish a coordinated plan of care for the beneficiary. The plan must specify the overall care to be provided and indicate, in detail, which services will be provided by the hospice and which will be provided by the facility.

If the hospice beneficiary has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

10.13.C. Service Provision

The following is intended for use as a guideline only. It identifies services for which the hospice is responsible, services that the hospice may arrange, and services that are "negotiable."

10.13.C.1. Services That Hospice Must Provide (Related to the Terminal Illness)

- A coordinated plan of care outlining the responsibilities of each provider;
- Intermittent (i.e., less than eight hours per day) nursing care of the hospice beneficiary;
- Counseling (defined as bereavement, nutritional, and spiritual); and
- Social work services.

10.13.C.2. Services That Hospice May Arrange (Related to the Terminal Illness)

- Spiritual care; and
- Home health aide/homemaker services. This applies only for services not provided during the facility's normal provision of care. For example, if the facility normally provides baths five times a week but the hospice plan of care calls for a bath each day, the hospice aide would provide baths on the days the facility does not.

10.13.C.3. Negotiable Services

Services that must be available for hospice beneficiaries but appropriate contracted providers may render, as related to the terminal illness and as included in the patient plan of care, include the following. These services are the responsibility of the hospice and **cannot** be billed to Medicaid by the contracted provider.

- Inpatient care for acute episodes of pain and symptom control;
- Inpatient respite care (not available for beneficiaries residing in a nursing facility);
- Laboratory;
- Pharmacy;
- Durable medical equipment, medical devices, and supplies;
- Radiology;
- Medical;
- Up to 24 hours of continuous care (at least eight hours of which must be nursing care) during periods of crisis;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology; and
- Emergency ambulance transportation (if the service is included as part of the hospice plan of care).

10.14 Hospital Services

A nursing facility must have in effect a transfer agreement with one or more hospitals.

10.14.A. Planned Inpatient Hospital Admission

When a hospital admission is planned, the beneficiary must be discharged from the nursing facility. The nursing facility must not count the day of discharge as reimbursable by Medicaid. This day is included on the hospital's claim when billing. The facility may not bill Medicaid for hospital leave days for a planned admission. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

10.14.B. Emergency Inpatient Hospital Admission

When a resident is admitted to the hospital on an emergency basis, the nursing facility may receive Medicaid reimbursement for holding their bed. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

10.14.C. Outpatient and Emergency Room

Outpatient and emergency room services are an ancillary service and are not included in the facility's per diem rate.

A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, and this day may be billed to Medicaid even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

10.15 Housekeeping and Maintenance

Facility and room/bed maintenance necessary to maintain a sanitary, orderly, and comfortable environment are a required service and included in the nursing facility's per diem rate.

10.16 Intravenous Therapy

Intravenous therapy nursing services, supplies and equipment (including all pumps) are included in the facility's per diem rate.

Pharmaceuticals used in IV therapy are an ancillary service and are not included in the facility's per diem rate.

10.17 Laboratory Services

Any nursing facility that performs laboratory services must be certified/accredited under the Clinical Laboratory Improvement Amendments (CLIA).

Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the CMS website. (Refer to Clinical Laboratory Improvement Amendments under Provider Resources in the Directory Appendix for website information.)

Laboratory services that can only be performed with special laboratory equipment by professional laboratory staff may be provided and billed by the appropriate enrolled ancillary provider (e.g., independent laboratory, outpatient hospital). Such services are not included in the facility's per diem rate.

Drawing, collecting and delivery of laboratory specimens are routine nursing services. As such, they are included in the facility's per diem rate regardless of who actually performs the service (i.e., nursing facility or ancillary provider).

10.18 Laundry Services

Facilities are responsible for general laundry services (e.g., bedding) and the beneficiary's personal laundry (e.g., clothing). Such services are included in the facility's per diem rate.

Dry cleaning services may be billed to the beneficiary if the beneficiary requests the service in writing, they have prior knowledge that the service is not covered by Medicaid, and they agree to accept the cost. A beneficiary's patient-pay amount may not be used to cover these costs.

10.19 Medically-Related Social Services

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include, for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

10.20 Mental Health Services

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as having a mental illness, intellectual/developmental disability or a related condition. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (Refer to the PASARR Process section of this chapter for more information.)

Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, intellectual/developmental disability or related condition services that are of lesser intensity than specialized services to all residents who need such services.

10.20.A. Specialized Services

Specialized services are those identified by the PASARR Level II and are provided or arranged by the CMHSP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia.

The PASARR Level II evaluation may provide recommendations regarding the specialized services and programs needed by the resident. Recommendations are based on evaluation of the resident's impairment in functional skills and the severity of those deficits. Nursing facilities must meet the responsibilities as outlined in this section for providing specialized services.

"Specialized Services" are defined as those mental health services for residents who have a mental illness, intellectual/developmental disability or a related condition which are:

- Of greater intensity than those normally required from a nursing facility;
- Provided in conjunction with usual nursing facility services;

- Determined through the PASARR process;
- Provided or arranged for by the local CMHSP acting on behalf of the State; or
- Result in the continuous and aggressive implementation of an individualized plan of care.

Specialized services for residents with **mental illness** may include, for example, individual, group and family psychotherapy, crisis intervention services, and formal behavior modification programs.

Specialized services for residents with a **intellectual/developmental disability or related condition** include specialized professional involvement because the service need is related to the resident's intellectual/developmental disability or related condition. Evaluators must carefully distinguish between those service needs that require the involvement of an intellectual/developmental disability professional and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of an intellectual/developmental disability professional to design and monitor the program.

For residents with **multiple diagnoses**, such as intellectual disability and mental illness or intellectual disability and dementia, evaluators may recommend either specialized services or other mental health services, depending on the interrelationship of the two diagnoses.

10.20.B. Nursing Facility Responsibilities

Responsibilities of the nursing facility include:

- Providing all of the usual and customary services (refer to the Medicaid Covered Services subsection) and as required by licensing and certification. This includes specialized mental health rehabilitation services as defined in 42 CFR 483.120.
- Monitoring the need for PASARR evaluations and ensuring that they are completed on time (refer to the PASARR Process section). The nursing facility must notify the CMHSP when a Level II evaluation is indicated.
- Collaborating with the resident or their legal representative and the CMHSP to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Coordinating the identified services (which may be obtained from the local CMHSP) and implementing and monitoring the services recommended in the individualized plan of care. Nursing facilities must also provide interventions which complement, reinforce and are consistent with any specialized services the individual is receiving or is required to receive by the State through the CMHSP. The individualized plan of care must specify how the facility will integrate relevant activities throughout all hours of the day at the facility to achieve consistency and enhancement of the goals identified in the individualized plan of care.

10.20.C. CMHSP Responsibilities

Responsibilities of the CMHSP include:

- Performing the comprehensive evaluation (Level II evaluation) when required by the PASARR Screening.
- Collaborating with the resident or their legal representative and the nursing facility to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Providing specialized services to nursing facility residents who have been determined to need them through the PASARR process. MDHHS has allocated funds to local CMHSPs for this purpose.
- Providing training to nursing facility direct care staff to implement and monitor the programs as designed, and participating in the evaluation and modification of the plan of care as needed.
- Providing services to nursing facility residents on the same basis as to all other persons in the region. A nursing facility may use the local CMHSP as a mental health service provider in order to fulfill the nursing facility's obligation to provide specialized mental health rehabilitation services. Services for residents with a primary diagnosis of dementia are also available from a local CMHSP on the same basis.

Every year, funds are made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities. Priority for use of these funds is for individuals with the most severe mental health problems who need specialized services. To the extent there are funds remaining after this priority group is served, MDHHS has given local CMHSPs authorization to serve individuals who need mental health services other than specialized services.

Ancillary providers of mental health services may bill Medicaid directly.

10.21 Nursing Care

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record
- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions

- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings
- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions
- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel
- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores
- Provision of bed baths
- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores
- Administration of intravenous solutions on a regular and continuing basis
- Administration of tube feedings
- Nasopharyngeal aspiration required for maintenance of a clear airway
- Care of a colostomy or iliostomy during early postoperative period, on an on-going basis, and conducting colostomy training
- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures
- Use of intermittent positive pressure breathing equipment and nebulizers
- Care of catheters
- Care of tracheostomies, gastrostomies, and other indwelling tubes
- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration
- Identifying the need for, and ensuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services
- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocolator
- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.)
- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living
- Normal range-of-motion exercises as part of routine maintenance nursing care
- Pain assessment and management

10.22 ORTHOTICS

Orthotics are an ancillary service and are not included in the facility's per diem rate.

10.23 Oxygen

The administration of oxygen and the related nursing services are included in the per diem rate.

Oxygen gas, equipment, and supplies for intermittent and infrequent use are included in the facility's per diem rate.

If a beneficiary requires frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day):

- As a resident in the Nursing Facility, the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility.
- As a resident in a County Medical Care Facility or a Hospital Long Term Care Unit, the oxygen gas, equipment, and supplies must be billed by the facility. A DME provider cannot bill for oxygen gas, equipment, and supplies for these residents.

NOTE: The rental of a concentrator **is** billable by a Medical Supplier and should not be confused as needing to be billed by the facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter in this manual for billing instructions.)

Oxygen services (i.e., gas, equipment, and supplies) are not covered by Medicaid if Medicare is paying for the stay. Medicare's per diem reimbursement rate includes the oxygen services.

10.24 Personal Comfort Items

Medicaid does not cover individual personal comfort items (e.g., telephone, television, radio, guest trays). Such services are not included in the facility's per diem rate. Beneficiaries may purchase individualized services with personal funds. A beneficiary's patient-pay amount may not be used to cover these services.

If the facility provides personal comfort items to all its beneficiaries (e.g., a television in the recreation room), the service is included in the facility's per diem rate.

10.25 Personal Hygiene Items

Items needed for personal hygiene are included in the facility's per diem rate. Such items include, but are not limited to, the following:

- Bacteriostatic soaps
- Body lotions
- Combs and brushes
- Cotton swabs
- Deodorant/ antiperspirant
- Facial tissues
- Hair conditioners (as appropriate)
- Incontinence supplies
- Medicine cups
- Oral hygiene supplies
- Patient gowns
- Personal hygiene preparations
- Safety razors
- Sanitary napkins
- Shampoo
- Shaving cream
- Soaps

10.26 Pharmacy

Nursing facilities must provide pharmaceutical services to meet the needs of each resident.

Prescriptions must be ordered and documented, in writing, in the beneficiary's medical record by the attending physician. These prescriptions comply with the federally mandated tamper resistant prescription pad policy as long as the beneficiary does not have the opportunity to handle the medical record. Additional information on the tamper resistant prescription pad policy can be found in the Pharmacy Chapter of this manual.

A Medicaid copayment is not required for prescription pharmaceuticals for nursing facility beneficiaries.

The Michigan Pharmaceutical Product List (MPPL) contains the over-the-counter and prescription pharmaceutical products covered by Medicaid and any restrictions placed on those products, including when prior authorization is required. The prior authorization process is outlined in the MPPL and may be obtained by the physician or their designee. The Michigan Pharmaceutical Products List is available online. (Refer to the Directory Appendix for website information.)

Pharmaceuticals dispensed in nursing facilities must be billed through a pharmacy (unless pharmacy is included in the per diem rate, i.e., ICF/IID).

10.26.A. Over-the-Counter Products (OTCs)

- The MPPL designates when an OTC drug is included in the facility's per diem rate. It is the responsibility of the facility to provide these products. Examples of OTCs in the per diem include mouthwash, topical antiseptics, analgesics, cough and cold preparations, ointments (both generic and brand name [e.g., Vaseline, Gold Bond]), and vitamins and minerals. The pharmacy or supplier must make arrangements with the nursing facility for reimbursement.
- OTCs not included in the per diem rate that may be billed to Medicaid, as outlined in the MPPL, are reimbursable to the pharmacy for nursing facility beneficiaries. Examples include Diphenhydramine and Insulin.

10.26.B. Medication Reviews

Medication reviews, as required by federal regulations, are the responsibility of the facility and are included in the per diem rate. The pharmacist must make arrangements with the facility for reimbursement of such services.

10.26.C. Return of Unused Drugs

Nursing facilities must, with a few exceptions for drugs such as controlled substances that are prohibited from being reused, properly credit Medicaid by returning unused prescription medications to the pharmacy. This policy applies to Medicaid beneficiaries where Medicaid is paying for the prescription medication. This does not apply to residents who have Medicare Part D.

The nursing facility must maintain documentation of:

- The quantity of medications dispensed and consumed by a beneficiary; and
- The return of all unused medications to the pharmacy so the pharmacy can credit Medicaid.

The nursing facility is required to return all prescription drugs that can be appropriately returned to the pharmacy due to the following reasons:

- Discontinuation in use by the prescriber
- Transfer to another facility (e.g., hospital or nursing facility)
- Discharge from nursing facility
- Death of beneficiary

The nursing facility and pharmacy may be subject to post-payment review to ensure the unused prescription drugs (as allowed by Federal and State law) are being returned by the nursing facility, and Michigan Medicaid is properly credited for the returned unused prescription drugs.

The nursing facility provider must not return prescription drugs to the pharmacy which are unsuitable for return according to State and Federal law.

The returned prescription drugs must:

- Have been properly stored
- Be returned unopened
- Not be a compounded product
- Be dispensed in the original packaging
- Be a non-controlled substance

The nursing facility should contact its contracted pharmacist consultant for assistance regarding which prescription drugs are not appropriate for return.

10.26.D. Beneficiary Pharmacy Insurance Deductible, Coinsurance, Copays and Premiums

10.26.D.1. Beneficiary Liability Under Medicare Part D

Beneficiaries who are enrolled in Medicaid and Medicare are considered dual eligibles. Dual eligibles who reside in nursing facilities do not have to pay premiums, coinsurance, deductibles and copays for prescription drugs if they are enrolled in a Medicare Part D plan. However, the Medicare Part D benefit requires that Medicaid make a payment(s) for nursing facility care for one full calendar month before the dual eligible is exempt from prescription drug copays.

Under either Medicare or Medicaid, a nursing facility is not responsible for paying the pharmacy for a beneficiary's liability (copays, deductibles, and/or coinsurance) unless the facility has assumed this obligation by contract or such payment is required by state law.

10.26.D.2. Coordination with Medicare Part D

Medicaid does not coordinate benefits with the Medicare Part D benefit. Medicaid does not reimburse a pharmacy for the beneficiary's liability for prescription drugs if the beneficiary is:

- Enrolled in a Medicare Part D plan and the prescription drugs are covered under the Medicare Part D benefit.
- Eligible to join a Medicare Part D plan but chooses to retain their commercial insurance in place of joining a Medicare Part D plan.

If a beneficiary joins a Medicare Part D plan that has a premium more than the Medicare standard premium established for Michigan, the beneficiary must pay the difference in the cost that Medicare does not pay.

10.26.D.3. Conditions When Nursing Facilities Can Offset the Patient-Pay Amount

The following table gives conditions on when a nursing facility can offset the patient-pay amount for the beneficiary's liability for prescription drugs.

If	Then
Beneficiary recently enters a nursing facility and their liability is not exempt under the Medicare Part D benefit until Medicaid has made a payment for one month, and it is established that the beneficiary will reside in the nursing facility for one month or more.	Nursing facility can offset the patient-pay amount for the beneficiary's liability during the initial month of the nursing facility stay.
Beneficiary is retroactively enrolled in Medicaid and their liability exemption under the Medicare Part D benefit has not yet taken effect.	The offsetting of the patient-pay amount for the beneficiary's liability can only occur for the first month if the retroactive enrollment in Medicaid is more than one month. The beneficiary's liability for subsequent months must be billed to the Medicare Part D plan by the pharmacy.
Beneficiary is prescribed drugs not covered by Medicare Part D, Medicaid or commercial insurance.	Nursing facility can offset the patient-pay amount.
Beneficiary has pharmacy copays, coinsurance, and deductibles from their commercial/private insurance.	Nursing facility can offset the patient-pay amount.

Nursing facilities cannot offset the patient-pay amount for insurance premiums.

Instructions for offsetting the patient-pay amount are contained in the Offset to Patient-Pay Amount for Noncovered Services section in the Billing & Reimbursement for Institutional Providers chapter.

10.26.D.4. Retroactive Medicaid and Medicare Part D Enrollment

If a beneficiary becomes retroactively enrolled in Medicaid and a Medicare Part D plan, a pharmacy can bill the Medicare Part D plan for the beneficiary's liability during the retroactive period in which the drugs were dispensed. However, in order for the pharmacy to bill Medicare Part D retroactively, the pharmacy must receive proof that Medicare Part D was made retroactive. The nursing facility can assist in getting the appropriate information to the pharmacy by obtaining the proof of retroactive eligibility from the beneficiary or the beneficiary's representative (this could be the facility). The pharmacy cannot make the decision of retroactive eligibility on its own. Hence, it is important that the nursing facility communicate with the pharmacy about the retroactive information so that the pharmacy can bill the Medicare Part D plan.

10.26.D.5. Beneficiaries Ineligible for Medicare Part D

For beneficiaries who are not eligible for the Medicare Part D benefit, Medicaid will continue to coordinate benefits with their commercial/private insurance.

10.26.D.6. Questions on Medicare Part D

Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D must be directed to Medicare. Also, the Michigan Medicare/Medicaid Assistance Program (MMAP) provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility). (Refer to the Directory Appendix for contact information.)

Beneficiaries must contact their/their spouse's employer human resources department for questions concerning the coordination of their commercial/private insurance and Medicare Part D.

10.27 Physician Services

Physician services must be provided and are an ancillary service. Such services are not included in the facility's per diem rate. In accordance with federal requirements, residents have the right to choose an attending physician.

A physician must initially examine a resident within 48 hours of admission to the nursing facility, unless the resident has been examined by a licensed physician within five days before admission and a copy of that examination is available in the facility at the time of the resident's admission. If the admission occurs on a Friday, the exam must be completed within 72 hours.

A physician must evaluate a beneficiary every 30 days for the first 90 days after admission. The resident must then be evaluated every 60 days unless otherwise justified and documented by the physician. At a minimum, the resident must be evaluated at least once every 90 days on an ongoing basis.

A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant, clinical nurse specialist or nurse practitioner.

10.28 Podiatry Services

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

10.29 Private Duty Nursing

Private duty nurses are not covered in a nursing facility by the Medicaid Program nor are they included in the facility's per diem rate. The beneficiary may use personal funds to purchase private duty nursing services. A beneficiary's patient-pay amount may not be used to cover the cost of private duty nursing.

10.30 Private Room

When a Medicaid beneficiary requires a private room due to medical necessity, the nursing facility is reimbursed at the usual per diem rate. Private rooms required for medical necessity are included in the facility's per diem rate. Written documentation of medical necessity must be part of the beneficiary's medical record.

Medical necessity is defined as a documented medical condition that creates the need to isolate the resident for their safety and/or the safety of others (i.e., infection control). This also includes behavioral conditions related to a medical condition (i.e., aggression related to dementia). The medical necessity must be documented, as well as addressed, in care planning and treatment.

In cases where a Medicaid resident needs to be in a private room because they require isolation due to an infection or illness, but no Medicaid-certified private rooms are available, the MDHHS Long-Term Care Operations section may provide a written exception to this policy. This exception is provided to allow the residents to reside in a non-Medicaid-certified bed within their facility on a short-term, temporary basis. Form MSA-0823 (Nursing Facility Isolation Bed Request) may be completed by the NF in need of isolating a Medicaid resident in a private room using a non-Medicaid-certified bed. Only forms approved by MDHHS may result in Medicaid reimbursement for Medicaid beneficiaries residing in a non-Medicaid-certified bed on a temporary basis. (Refer to the Forms Appendix for a sample form.)

If a beneficiary requests a private room and there is no medical necessity, the beneficiary may elect to pay privately. The nursing facility must advise the beneficiary that a private room is not a Medicaid-covered service unless it is medically necessary, and that the beneficiary or family is responsible for paying the difference between the cost of a semi-private and private room. The facility may only charge the difference between what it would normally charge a private-pay resident for a semi-private and a private room. Facilities may not charge beneficiaries the difference between the Medicaid per diem rate and the rate charged a private-pay resident for a private room. For example, if the facility charges $98.00/day for a semi-private room and $112.00/day for a standard private room, the charge is $14.00/day. The beneficiary's patient-pay amount may not be used for this purpose.

If the beneficiary agrees to pay the difference between the semi-private and private room rate, the beneficiary or family member must request permission, in writing, from MDHHS. The Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580) is used to obtain the permission. The MSA-1580 is completed by the beneficiary or family member. (Refer to the Forms Appendix for a copy of MSA-1580.) Requests to supplement the cost of a private room are reviewed for cost and reason for request on a case-by-case basis. A response will be sent to the requestor, the beneficiary (if different), and the facility within ten working days.

This response must be retained as part of the beneficiary's medical record. Subsequently, these charges are subject to audit by MDHHS, CMS or designated representatives of either of those entities. These charges must be reported by the nursing facility as revenue received. This response, however, does not guarantee that the beneficiary will be provided a private room. The agreement to provide a private room is given by the nursing facility.

If a Medicaid beneficiary is in a private room (either Medicaid-certified or dually-certified) because the private room is the only bed available, the facility cannot request the beneficiary or beneficiary's family pay the difference between the semi-private and the private room rate, nor can the facility transfer or discharge the beneficiary due to non-payment of the difference.

10.31 Prosthetics

Prosthetic services are an ancillary service and are not included in the facility's per diem rate.

10.32 Radiology

Radiology services are an ancillary service and are not included in the facility's per diem rate.

10.33 Substance Abuse Services and Treatment

Services rendered for the treatment of alcohol and drug abuse are an ancillary service and are not included in the facility's per diem rate.

10.34 Supplies, Accessories and Equipment

Supplies, accessories, and equipment necessary to achieve the goals of the beneficiary's plan of care are included in the facility's per diem rate and must be available to the beneficiary. Medical supplies, accessories, and equipment include, but are not limited to:

- Atomizers
- Bandage products
- Bed linens
- Bib or protective cover
- Catheters/accessories and irrigation solution
- Cloth diapers
- Cotton balls
- Cotton swabs

- Deodorizers
- Diagnostic agents (e.g., Testape, Kyotest)
- Disposable diapers
- Disposable gloves
- Dressings (e.g., surgical pads, cellulose wadding, tape)

  Note: Some supplies for complex wound care are not included in the per diem rate and must be obtained through a medical supplier or pharmacy. Supplies that must be billed by a medical supplier, including information for interpreting the list of supplies, are on the MDHHS website. (Refer to the Directory Appendix for additional information.)
- Elastic hose
- Enema kits
- Finger cots
- First aid trays
- Flameproof cubicle curtains
- Foot soaks
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes
- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths

- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses

Note: This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

10.35 TELEMEDICINE

A nursing facility can be either an originating or distant site for telemedicine. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee. Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

10.36 THERAPIES

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care. Non-routine occupational therapy (OT), physical therapy (PT) and speech therapy (ST) are ancillary services that are covered separately from the per diem rate if the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician/licensed physician's assistant for each calendar month of therapy; and
- The written orders must be signed by the attending physician/licensed physician's assistant or other licensed practitioner practicing within their scope of practice as defined in State law for OT, PT, and SLT and retained in the beneficiary's medical record.

Non-routine therapies do not require prior authorization (PA) for Medicaid beneficiaries residing in a skilled nursing facility within 60 days of their admission to the facility. Providers must obtain PA for any non-routine therapy services that are provided after the initial 60-day post-admission period. This change only applies to new admissions to a nursing facility. Subsequent emergency or planned hospitalizations do not impact the requirements for PA. A copy of the physician prescription or documented clearance to resume therapy must be retained in the beneficiary's medical record. Refer to Prior Authorization within the Therapy Services chapter of this Manual for additional information.

Refer to the Therapy Services Chapter of this manual for additional information.

Non-routine OT, PT and SLP services are included in the Patient Driven Payment Model (PDPM) rates paid to State Veterans' Homes. State Veterans' Home providers are to bill for non-routine therapies on the same claims as daily care. All therapy services require prior authorization.

10.37 TRANSPORTATION

10.37.A. NON-EMERGENCY NON-AMBULANCE TRANSPORTATION

The nursing facility is responsible for non-emergency non-ambulance transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. This transportation includes transport to medical appointments/treatment not available in the facility (e.g., dialysis treatment), as well as when the facility arranges for services to be provided at the facility (e.g., hearing aid dealer). The facility must either arrange or provide transportation. Reimbursement for non-emergency non-ambulance transportation, whether the beneficiary is transported to the appointment or the services are provided at the facility, is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.

Excluded from the per diem rate are charges for the transportation of equipment for portable x-ray services by an enrolled Portable X-ray Supplier. (Refer to the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapter of this manual for additional information.)

Travel to out-of-state medical providers (other than Michigan Medicaid-enrolled "borderland" providers as defined in the General Information for Providers chapter of this manual) is not the responsibility of the facility and must be prior authorized by MDHHS.

The facility must select the most appropriate, cost-effective mode of transportation. Whenever possible, a facility-owned vehicle should be used. This vehicle must comply with the Americans with Disabilities Act (ADA).

In rare situations, the condition of a beneficiary needing non-emergency transport requires an attendant in addition to the driver. In such cases, it is appropriate for a nurse aide to accompany the beneficiary and this cost should be reflected in the annual cost report as "staffing costs associated with providing needed medical care." Sending a nurse aide or other staff member with the beneficiary being transported must not negatively impact the care of residents remaining in the facility.

The need for a nurse aide to accompany a beneficiary must not be confused with the responsibility of the family or legal guardian "to attend the beneficiary if escort is needed to sign consent forms, decide treatment options, sign insurance forms, provide histories, etc." A nurse aide is not to be responsible for these legal and medical decisions and knowledge.

10.37.B. EMERGENCY AMBULANCE

Nursing facilities must have contractual arrangements for ambulance services for emergencies. When there is an emergency, an ambulance provider renders the service and bills Medicaid.

10.37.C. Non-emergency Ambulance

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may only bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. The written order must contain, at a minimum, the following information:

- Beneficiary's name and Medicaid identification (ID) number;
- Attending physician's NPI number and attending physician or provider signature;
- Type of transport necessary;
- Explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used);
- Origin and destination;
- Diagnosis;
- Frequency of needed transports (required for ongoing, planned treatment); and
- Type of ongoing treatment (required for ongoing, planned treatment).

A separate physician's order is required for each individual transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the beneficiary, beneficiary's family or used to offset the patient-pay amount. The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.

10.38 Vaccines

Reimbursement for any vaccination ordered by the attending physician and administered in the nursing facility is included in the per diem rate. The invoiced purchase cost of the vaccine should be included as an allowable medical supply expense on the facility's cost report.

10.39 Vision

Vision services (examinations and glasses) are ancillary services and are not included in the facility's per diem.

A Medicaid copayment is not required for nursing facility beneficiaries.

SECTION 11 – SPECIAL PLACEMENTS AND AGREEMENTS

11.1 DEMENTIA UNITS

A nursing facility may elect to designate beds or units to address the special needs of beneficiaries with Alzheimer's disease or other dementing illnesses. Care for Medicaid beneficiaries in dementia specialty beds is reimbursed as defined for any other nursing facility bed.

11.2 HOLDING A BED (HOSPITAL LEAVE AND THERAPEUTIC LEAVE)

Medicaid reimburses the nursing facility for holding a bed while the beneficiary is admitted to a hospital for emergency medical treatment (hospital leave) or takes a therapeutic leave from the facility for non-medical reasons.

Prior to therapeutic leave or transfer to a hospital, providers must give written notice of the facility's bed hold and readmission policy to the beneficiary and a family member or legal representative. This must include information about Medicaid coverage for therapeutic and hospital leave. In an emergency, notice must be given to the beneficiary and family or legal representative within 24 hours. If the beneficiary refuses to have a family member notified, this must be documented in the beneficiary's record.

The hospital leave portion of this policy only applies when Medicaid is the primary payer for room and board for the nursing facility stay at the time of the emergency hospital admission. For beneficiaries who are dually eligible for Medicare/Medicaid or have other insurance, Medicaid will not reimburse for holding a bed if Medicare or the other insurance is the primary payer for room and board for the nursing facility stay at the time of hospital admission. Medicaid will reimburse for the bed, however, if the resident who was Medicaid at the time of the hospitalization returns to the facility within the ten-day period with Medicare or other insurance coverage for the subsequent stay.

The written notice must specify:

- The Medicaid bed hold policy under which the beneficiary is permitted to return and resume residence in the facility; and
- The facility's written policy under which a beneficiary is readmitted to the facility when their absence is in excess of the Medicaid-reimbursed leave days.

The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible.

NOTE: This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.

11.2.A. Hospital Leave Days

Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary's temporary absence from the facility due to admission to the hospital for emergency medical treatment only when the facility's total available bed occupancy* is at 98 percent or more on the day the beneficiary leaves the facility. "On the day" is defined as the facility's census at midnight (i.e., 12:01 a.m. – the first minute of the day).

Facilities at 97.50 percent occupancy or more may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent.

Occupancy includes all licensed beds (e.g., Medicaid-certified, dual Medicare/Medicaid certified, licensed only). The 98 percent or more occupancy does not include beds held open for hospital or therapeutic leave day(s).

In cases where a facility's available bed occupancy is below 98 percent on the day the beneficiary leaves for an emergency admission to the hospital, but rises to 98 percent or more during their hospital stay, no hospital leave days can be billed for the beneficiary. Hospital leave days are only billable for a beneficiary if the occupancy rate is 98 percent or more on the day the beneficiary leaves the hospital.

In cases where the available bed occupancy is at 98 percent on the day the beneficiary leaves and drops below 98 percent during their hospital stay, the facility may bill up to 10 hospital leave days.

In instances where a facility is enrolled with Medicaid and has more than one provider NPI number, the available bed occupancy must be calculated separately for each provider NPI number.

Examples of Worksheet for Determining % of Occupancy

		Example 1	Example 2
A.	Total Licensed Beds (excluding beds in an approved non-available bed plan and/or beds disapproved by LARA for occupancy)	179	140
B.	Number of Total Licensed Beds Not Occupied (unoccupied beds available for a new resident)	2	7
C.	Beds for Residents on Hospital Leave (Medicaid or private pay is paying to hold the bed)	6	8
D.	Beds for Residents on Overnight Therapeutic Leave	0	10
E.	Total Residents on Leave (C + D = E)	6	18
F.	Adjusted Licensed Beds (A – E = F)	173	122
G.	Number of Residents Physically in Facility (total occupancy minus total residents on leave) (A – B – E = G)	171	115

* Calculation of available bed occupancy for purposes of Medicaid reimbursement for hospital leave days is different than calculation of occupancy for cost reporting purposes.

Examples of Worksheet for Determining % of Occupancy

		Example 1	Example 2
H.	Occupancy (number of residents physically in facility divided by adjusted bed capacity) (G / F = H)	171 / 173 = 99%	115 / 122 = 94%

Facilities billing for Hospital Leave Days must document in the beneficiary's medical (clinical) record what the facility's census was at the time the beneficiary left the facility for a hospital leave.

The facility must hold the bed and may bill Medicaid if there is reasonable expectation by the attending physician at the point of admission to the hospital that the beneficiary will return to the nursing facility by the end of the tenth day. The hospital admission must be for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or their unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The beneficiary must return to the nursing facility in ten or fewer days in order for the nursing facility to bill Medicaid for hospital leave days.

If the beneficiary is in the hospital for more than ten days, the nursing facility is released from its obligation to hold the bed and cannot bill Medicaid for any hospital leave days. The resident may be charged to hold the bed for those days if they agree in advance. (See Medicaid Non-Covered Leave Days subsection.) The facility is encouraged to monitor the resident during the hospital stay to determine the likely length of hospitalization.

If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill Medicaid for the hospital leave days up to the day before the resident died.

If the resident returns to the nursing facility under Medicare coverage, and was Medicaid eligible prior to the emergency admission, the facility may bill Medicaid for the hospital leave days if the emergency hospitalization was for ten days or fewer.

A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is re-admitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the

resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

The resident need not be shown on the Medicaid claim as discharged from the nursing facility unless the hospital admission was a planned admission (not an emergency) or was longer than 10 days. NOTE: If the claim does show discharged, the facility is reminded of Medicaid's readmission policy. The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible. This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. CHAMPS automatically deducts the patient-pay amount and reimburses the provider for the balance. If the facility bills Medicaid for hospital leave days that occur at the beginning of the month, then the nursing home should collect the patient-pay amounts as usual. The facility should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a resident has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay is 10 days or fewer), the nursing facility should collect the patient-pay amount from the resident, then submit a Medicaid claim. Medicaid would reimburse the facility the hospital leave day per diem rate, minus the patient-pay amount. Using 2002 figures, the facility reimbursement would be $150.30 [($70.06 x 5)-$200].

There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay.

Medicaid hospital leave days are not included in the Medicaid census statistics. Leave days reimbursed by other payer sources must be included in the census statistics.

11.2.B. Therapeutic Leave Days

If the beneficiary has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, Medicaid reimburses the facility to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons, such as overnight stays with friends or relatives. A resident is counted in the facility census if they are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.

The Medicaid Program covers up to 18 therapeutic leave days in a 365-day period for each beneficiary if:

- The facility reserves the bed for the beneficiary during their absence; and
- The beneficiary's written plan of care provides for out-of-facility visits; and
- The beneficiary returns to the facility.

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning April 10, 2003, that resident has 13 therapeutic leave days remaining until April 9, 2004.

If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date they left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Therapeutic leave days must be included in the Medicaid census statistics if the therapeutic leave day is being paid by the beneficiary or Medicaid.

11.2.C. Medicaid Non-Covered Leave Days

Medicaid does not reimburse providers to hold a bed for reasons other than emergency transfer to a hospital (10-day maximum per hospital admission), or therapeutic leave (18-day maximum per 365-day period). However, the facility may hold the beneficiary's bed for other reasons and for leave days not covered by Medicaid, and bill the beneficiary if the beneficiary:

- Has prior knowledge that the service is not a Medicaid benefit; and
- Desires to have the bed reserved; and
- Agrees, in writing, to pay the facility to hold the bed at a specified rate. (The beneficiary's patient-pay amount may not be used for this purpose.)

If the beneficiary elects to not pay privately, the beneficiary has the option to return to the next available, equivalent bed. A beneficiary cannot be involuntarily transferred/discharged after a temporary absence, including discharge to obtain acute care in an inpatient hospital, unless the appropriate criteria are met and the appropriate regulations, policies, and procedures are followed.

Except for Medicaid-covered leave days and when beneficiaries have paid to hold a bed, the beneficiary must be discharged from the facility and then readmitted upon return to the first available bed.

All paid bed hold days (excluding Medicaid hospital leave days) must be included in the Medicaid cost report census statistics.

11.3 Involuntary Transfer or Discharge

11.3.A. Conditions

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *
- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances.

11.3.B. Transfer Trauma

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay.)

The SSA evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has

* Items require documentation of medical necessity by the attending physician.

been in the nursing facility and the relationships that the resident has formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary' s medical need to remain in a bed not certified for their present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDHHS will change the Benefit Plan Assignment, which can be appealed by the beneficiary or their designated representative.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

11.3.C. BENEFICIARY NOTIFICATION

Nursing facilities must give beneficiaries a 30-day written notice regarding transfer unless:

- The transfer or discharge is a health care emergency;
- The safety or health of beneficiaries or staff is endangered;
- The beneficiary agrees to the transfer/discharge;
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; or
- The facility ceases to operate.

The notice must include:

- The reason for the transfer or discharge;
- The effective date of the transfer or discharge;
- The location to which the beneficiary will be transferred or discharged;
- The name, address, and (toll-free) telephone number of the State Long Term Care Ombudsman;

- For beneficiaries with developmental disabilities (DD), the mailing address and telephone number of the agency responsible for the protection and advocacy of DD individuals, established under the Developmental Disabilities Assistance and Bill of Rights Act;
- For nursing facility beneficiaries with mental illness (MI), the mailing address and telephone number of the agency responsible for the protection and advocacy of MI individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act; and
- Appeal rights.

The facility must also provide:

- Sufficient preparation and orientation to beneficiaries to ensure safe and orderly transfer or discharge from the facility, as required by state and federal regulations; and
- Notice of the facility's bed-hold and re-admission policy, including the Medicaid bed-hold policy.

If a nursing facility elects to discontinue operations (voluntary closure) or withdraw from the Medicaid program, the facility must provide notice to the beneficiary as outlined above not less than 30 days before the closure or withdrawal. The notice must be sufficient to allow for suitable relocation arrangements.

11.4 Married Couples

When married beneficiaries or blood relatives live in the same Medicaid nursing facility, they may share a room if both spouses or their relatives consent. (This policy applies only to beneficiaries who both require nursing facility services. It does not apply when one beneficiary does not require nursing facility services. For example, if both spouses wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services. If only one of them requires nursing facility services, Medicaid only covers services for that person.)

11.5 Complex Care

The Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The authorization covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDHHS to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities

- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment.

Program requirements:

- Referrals must come from the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- Nursing facilities may request approval after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the nursing facility. The nursing facility must request approval within 30 days from the date of admission to the nursing facility.

The following information must be submitted:

- A completed MSA-1576, including any requests for additional nursing, CENA, supplies or equipment. **NOTE:** The only supplies or equipment that will be considered are those not included in the facility's per diem rate or not separately billable by a Medicaid-enrolled medical supplier. An electronic copy of the form is available on the MDHHS website. (Refer to the Directory Appendix for website information.) (Refer to the Medicaid Service Descriptions Section of this chapter for information regarding what services are to be provided by the NF as part of the daily per diem reimbursement.)
- The beneficiary's medical background, including:
  - current medical status;
  - admitting history and physical;
  - a copy of all consultations;
  - most recent three-day physician progress notes;
  - treatment/nursing care plan; and
  - justification for any additional nursing hours and/or special equipment requested.

  (This information should be included on the MSA-1576.)
- Recent (within the past 30 days) lab, x-ray, and diagnostic or therapeutic test results or reports.
- A list of 10 nursing facilities (as documented by the hospital) within a 50-mile radius that have denied admission, including:
  - Name, address, and telephone number of the nursing facility
  - Contact person's name and title
  - Date of contact
  - Reason for denial
- Documentation of the financial resources available to the beneficiary, including:
  - Medicaid coverage

- Medicare Parts A and B
- Other commercial insurance coverage.

- Name and telephone number of a contact person at the nursing facility seeking the additional reimbursement for complex care.

It may take up to 15 business days for the MSA-1576 to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the MSA-1576 as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.

MDHHS will make a determination and return to the provider a letter indicating approved, denied, insufficient data, no action, or approved as amended. If approved, the approval letter will contain a PA number with start and end dates. To renew a request, the facility must submit another MSA-1576 at least 15 business days prior to the expiration/end date.

A beneficiary residing in a nursing facility with an active complex care prior authorization for vent care for two consecutive years must receive a pulmonary evaluation at the beginning of the third year and annually thereafter. A beneficiary may be exempt from the annual pulmonary evaluation if, at the time the scheduled evaluation is due, the beneficiary elects not to have the evaluation, the physician documents a medical reason to not perform it, or the beneficiary received a pulmonary evaluation within the current year, such as during a hospital stay. If the beneficiary chooses not to have the evaluation, the nursing facility must notify the beneficiary's physician of that decision. Documentation of the decision to decline the evaluation by either the beneficiary or the physician must be in the beneficiary's medical record.

11.6 One-Day Stay

A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

A one-day stay must be included in the Medicaid census statistics.

11.7 Religious Non-medical Health Care Center

Religious Non-medical Health Care Centers may be licensed as nursing facilities and certified for Medicaid. Beneficiaries in Medicaid-certified facilities, under the care of a practitioner, may be determined to be in need of nursing care and, therefore, covered by Medicaid.

SECTION 12 – SPECIAL PROVIDER TYPE COVERAGES AND LIMITATIONS

12.1 HOSPITAL SWING BEDS

In order to address the shortage of rural nursing facility beds, federal requirements allow rural hospitals to provide post-hospital extended care services. Such a hospital, known as a swing bed hospital, can "swing" beds between hospital and nursing facility levels of care on an as-needed basis. In order to receive Medicaid reimbursement, hospital swing beds must meet all applicable state and federal requirements and provide all required services.

Providers of hospital swing bed services may bill Medicaid for hospital swing bed days only when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid inpatient diagnosis related group (DRG) of the admission. Hospitals that are exempt from the DRG reimbursement system may bill for Medicaid-covered swing bed days beginning the day of admission to the swing bed.

The total number of Medicaid-reimbursed hospital swing bed days is limited to 100 days per beneficiary per calendar year.

A hospital swing bed provider must not provide extended care services if the hospital owns or operates a hospital long-term care unit that has beds available at the time a patient requires admission for extended care services.

Medicaid does not require the MDS for clinical assessment purposes or reimbursement for beneficiaries in hospital swing beds. The PASARR process must be completed, as outlined earlier in this chapter, prior to placement in a nursing facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for additional swing bed billing instructions.)

12.2 VENTILATOR-DEPENDENT CARE UNITS

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services, and for which there is an enhanced Medicaid reimbursement.

12.2.A. PLACEMENT CRITERIA

A request for placement must show that the:

- Beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- Beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 207.

Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BIPAP. If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post-acute setting. If there is no weaning potential and the beneficiary does not require rehabilitative services, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

The MHP is responsible for initiating disenrollment of a beneficiary by submitting the Request for Disenrollment Long Term Care form (MSA-2007) to MDHHS.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. When the beneficiary is in a hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

The hospital cannot charge a beneficiary the difference between the hospital's charge and the MDHHS payment for nursing days.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

12.2.B. Authorization for VDCU Placement

To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the VDCU must contact (by telephone) the MDHHS Program Review Division (PRD) for authorization. MDHHS will consider the request for ventilator-dependent unit care based on current Medicaid policy. The request will be approved or denied immediately during the telephone call. (Refer to the Directory Appendix for contact information.)

Note: If the PA request is approved, MDHHS will:

- request the VDCU's National Provider Identifier (NPI) for inclusion in the prior authorization record; and
- provide the VDCU with a prior authorization number for billing purposes.

The nursing facility must report any change of condition, such as weans from ventilators, transfers, discharges, re-hospitalizations and deaths of these complex care residents to MDHHS.

Residents who are weaned from their ventilators will be allowed a 14-day stay in the VDCU from the date they are removed from the ventilator, at the allotted VDCU reimbursement rate, in order to assure complete wean is maintained. Once the 14 days of successful wean has been maintained, it is then the responsibility of the VDCU to transfer the resident to a Medicaid LTC bed within the facility, transfer the resident to

another nursing facility, or discharge the resident home with appropriate care planning involving family, responsible party, and community resources. Once successful wean has been maintained, the PA number will be end-dated.

If a beneficiary is in need of therapy, prior authorization for the therapy must be obtained under the VDCU's NPI. (Refer to the Nursing Facility Claim Completion section of the Billing & Reimbursement for Institutional Providers chapter for additional information.)

12.2.C. Non-Authorization of New Admissions to a Medicaid Approved VDCU if Facility Has a Survey Citation of Actual Harm

New admissions to a VDCU will not be approved from the date a nursing facility receives the CMS-2567 (written survey report) containing the survey citation at a level of actual harm or higher on the scope and severity grid (G, H, I, J, K or L) pertaining to a resident or residents of the VDCU. Authorizations of new admissions will resume when the Department of Licensing and Regulatory Affairs, State Survey Agency notifies the State Medicaid Agency that all deficiencies have been corrected and the facility has been found to be in substantial compliance. This policy does not apply to the renewal of authorizations for Medicaid beneficiaries residing in a VDCU prior to the survey citation of actual harm.

CERTIFICATION, SURVEY & ENFORCEMENT APPENDIX

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SECTION 1 – INTRODUCTION

Michigan Department of Health and Human Services (MDHHS), under an approved State Plan as required by the Social Security Act, is responsible for annual Medicaid certification of all nursing facilities (other than State-owned facilities, such as a State Veterans' Home). Michigan Department of Licensing and Regulatory Affairs (LARA) is responsible for ensuring all Medicaid-certified nursing facilities are in compliance with Health Survey and Life Safety Code Survey requirements.

As required by federal law, the State Medicaid Agency (MDHHS, Behavioral and Physical Health and Aging Services Administration [BPHASA]) has entered into an interagency agreement with the State Survey Agency (Michigan Department of Licensing and Regulatory Affairs [LARA], Bureau of Survey and Certification [BSC]) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts State Survey Agency (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.

For the purposes of this appendix, a Medicaid-certified nursing facility (NF) is defined as a non-state-owned nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. This appendix includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies when facilities are not in compliance with applicable requirements.

SECTION 2 - MEDICAID CERTIFICATION AND DE-CERTIFICATION OF NURSING FACILITY BEDS AND MEDICAID PROVIDER ENROLLMENT

This Section describes Medicaid certification requirements for nursing facilities, certification and de-certification of nursing facility beds, and how nursing facility providers enroll in Medicaid.

The SMA is responsible for initial certification and annual certification of beds for nursing facilities seeking Medicaid reimbursement. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA.

2.1 DUAL CERTIFICATION

MDHHS requires all new Medicaid-certified nursing facility beds to also be certified for Medicare. Applications for certification of new Medicaid beds that are not Medicare-certified will be denied. Applications for initial Medicare certification may be made to the LARA-BSC. Facilities must meet state and federal regulations for certification.

Providers may seek annual certification of nursing facility beds currently certified as Medicaid-only. Beds that were certified as Medicaid-only as of August 1, 2004 are not required to become Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on August 1, 2004. However, MDHHS strongly encourages Medicare and Medicaid (dual) certification of all nursing facility beds in order to maximize access for beneficiaries.

A nursing facility that has certified beds that were granted an exception under this policy, and that is subsequently involved in circumstances that would require it to enroll with Medicaid (such as a change in ownership), must secure Medicare certification for Medicaid beds within one year. A provider's failure to secure dual certification for all Medicaid-certified beds will result in denial of Medicaid certification and termination of Medicaid enrollment.

A provider that applies for new Medicaid certification for some beds in a nursing facility must dually certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the existing Medicaid-certified beds were granted an exception under this policy. For example, a nursing facility has a distinct part or unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and applies for Medicaid certification for the new beds. The new beds will be approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit.

A licensed nursing facility entity that becomes a provider as a result of the purchase of a previously closed or currently operating Medicaid-only nursing facility must receive Medicare certification for all Medicaid-certified beds in that nursing facility within one year from the date of purchase of an operating nursing facility or the date of reopening of a previously closed nursing facility. The provider will receive a provisional Medicaid provider agreement while pursuing Medicare certification of the Medicaid-certified beds. This provisional agreement is time limited and holds the provider to the loss of Medicaid certification and disenrollment without appeal if Medicare certification is denied. If warranted, the SMA may grant an additional grace period contingent upon evidence that substantial progress has been made toward Medicare certification. Failure to meet this requirement will result in de-certification of the Medicaid beds and termination of Medicaid enrollment.

A nursing facility that currently has Medicare certification of its Medicaid beds must maintain the dual certification. A nursing facility that voluntarily disenrolls or decertifies beds from Medicare will lose Medicaid certification of those beds. A nursing facility that loses its Medicare certification through the Centers for Medicare & Medicaid Services (CMS) regulatory enforcement actions will automatically lose its Medicaid certification. An exception or exemption to this dual certification may be made pursuant to the provisions contained in Section 21718 of P.A. 368 of 1978 (MCLA 333.21718). Any exception or exemption granted to a nursing facility under Section 21718 of P.A. 368 of 1978 prior to August 1, 2004 will be recognized.

Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit (HLTCU) beds, are also required to dually certify these special population beds (e.g., ventilator dependent care beds, behavioral, acquired or traumatic brain injury/spinal cord injury [ABI/TBI/SCI]). ICF/IID or MI beds need not be dually certified.

A provider must apply for and receive dual Medicaid and Medicare certification for new Medicaid beds acquired through the CON process, e.g. new construction or the redistribution of certified beds.

All beds approved pursuant to CON Review Standards for nursing home and HLTCU beds must be dually certified for Medicare and Medicaid. Beds approved under this subsection shall not be converted to or utilized as general nursing home use without a CON for nursing home and hospital long-term care unit beds; and shall not be offered to individuals other than the special populations they were initially approved for.

2.2 Medicaid Bed Certification Limits

Individual facilities seeking to enroll in the Medicaid program or seeking to increase the number of Medicaid-certified beds must apply as outlined in the Medicaid Nursing Facility Bed Certification Process subsection of this appendix. Applications to the SMA will be reviewed in date order and must be received 45 days before the first of the month beginning the next quarter of the provider's cost reporting year. MDHHS will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit (set in 1996 at 47,542), based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection. Preference will be given to facilities that are applying for Medicaid certification in order to dually certify beds, to facilities that are creating innovative living environments for beneficiaries who choose nursing facility care, and to facilities in geographic areas with limited Medicaid accessibility. Changes in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

2.3 Criteria for Evaluation of Medicaid Bed Certification Applications [Change Made 4/1/2025]

The State Medicaid Agency (SMA) (MDHHS Behavioral and Physical Health and Aging Services Administration [BPHASA]) will collaborate with the State Survey Agency (SSA) (Department of Licensing and Regulatory Affairs [LARA]) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. MDHHS will grant Medicaid bed certification if the application meets all the following:

- A verification from the SSA that the beds listed in the applications are Medicare-certified.

- The SSA finds that the facility named in the application is in substantial compliance with federal regulations at the time of application.
- If there is an accepted submitted plan of correction for any survey activity occurring following the date of the application submission, the facility named in the application will be deemed to have satisfactory survey performance. **(text revised per bulletin MMP 24-54)**

2.4 Medicaid Nursing Facility Bed Certification Process

Current providers who wish to change their Medicaid-certified beds (increase, decrease, relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. A written application to change Medicaid-certified beds must contain the following:

- Number and location of facility beds.
- Current certification designation of all facility beds by unit or wing.
- Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds.

A provider may apply for a change in Medicaid bed certifications any time throughout the year up to once per quarter.

The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Chapter 3, Section 3202, Change in Size or Location of Participating SNF and/or NF.

MDHHS will respond to Medicaid bed certification applications with a determination within 45 days of receipt of all requested information.

2.4.A. Bed Certification Process for Medicaid Enrolled Providers

Nursing facilities that are currently enrolled with Medicaid and want to change their number of Medicaid-certified beds must file a written application to both LARA (BSC) and MDHHS (SMA). (Refer to the Directory Appendix for application mailing instructions related to Medicaid bed certification changes.) The SMA and the SSA will collaborate regarding the consideration and disposition of applications for additional Medicaid beds. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications and the Dual Certification subsections of this appendix.

Once the SMA makes a determination regarding the application for additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) will be notified, in writing, by the SMA. If the application is denied, the provider will be notified of their appeal rights in writing. If the application is approved, the SSA will be notified by the SMA of the change. The SSA will also notify the provider of the change.

2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid

This subsection applies to providers operating existing facilities that have not previously participated in the Medicaid Program, or providers seeking to certify Medicaid beds following the loss of certification due to a regulatory action.

Non-Medicaid providers seeking to receive Medicaid certification for nursing facility beds and receive Medicaid payment must file a written application with both the SSA and with the SMA. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of this appendix.

Once the SMA makes a determination regarding the application for Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified, in writing, by the SMA. If the application is denied, the SMA will notify the provider of their appeal rights in writing. If the application is approved, the SMA will notify the provider and the SSA of the change. The SSA will also notify the provider of the change.

The provider must also enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection of this appendix.

2.4.C. Bed Certification Process During a Change in Ownership (CHOW)

A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDHHS. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA, the SMA/Long Term Care Policy Section and RARSS. (Refer to the Directory Appendix for contact information.)

The following are changes in ownership that must be reported to the SMA and the SSA, regardless of whether a CON is required:

- A change from sole proprietorship to partnership or corporation,
- A change from partnership to sole proprietorship or corporation,
- A change from corporation to sole proprietorship, partnership or corporation,
- Sale or lease of a nursing facility,
- Transfer or sale of stock resulting in a change of the controlling interest in a privately held company,
- Consolidation or merger of two or more corporations that results in the creation of a new corporation.

If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were

under the previous owner. However, if the facility has beds designated as Medicaid-only, the new owner must dually certify all Medicaid beds within one year as outlined in the Dual Certification subsection. As part of the CHOW approval process, the SMA may deny bed certifications and recommend against Medicaid enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection. In addition, dual certification requirements apply as outlined in the Dual Certification subsection.

If the new owner wants to change the bed certifications, a written application must be filed with the SSA and with the SMA/Long Term Care Policy Section. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for changes in the Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection.

Once the SMA makes a determination regarding the application for changes in the Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the RARSS will be notified, in writing, by the SMA. If the application is denied, the SMA will notify the provider of appeal rights in writing. If the application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.

A new owner is considered a new provider and must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection, regardless of whether any bed certification changes are made.

Under a change of ownership (CHOW), a nursing facility must not notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Rather, the change of ownership submission completed by the facility in the CHAMPS Provider Enrollment subsystem will automatically update the admission or discharge data for these beneficiaries in CHAMPS by moving them to the new NPI once the change of ownership is approved by MDHHS staff. Nursing facilities will not be required to update the admission or discharge data in CHAMPS for these beneficiaries when a change in ownership occurs.

2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds [Change Made 4/1/2025]

A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license nursing facility beds must first receive approval through the CON process within MDHHS.

Providers seeking to receive Medicaid certification for new nursing facility beds and receive Medicaid payment must file a written application with both the SMA and the SSA. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for Medicaid bed certifications. Medicaid approval or denial of the application

for additional bed certifications will be based on the Criteria for Evaluation of Medicaid Bed Certification Applications.

Once the SMA makes a determination regarding the application for new or additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified in writing. If the application is denied, the SMA will notify the provider of appeal rights in writing. If the application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.

If not already enrolled, the provider must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection.

Medicaid may enter into a provisional enrollment with a provider (or the owner or management company) that does not meet the above criteria if:

- The applicant and the owner or management company take actions acceptable to MDHHS to correct, improve or remedy any conditions or concerns that would result in denial of the application; and
- The applicant and the owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medicaid enrollment. Failure of the provider to comply with the terms of the conditional agreement will result in termination without appeal of the provisional Medicaid enrollment. **(text added per bulletin MMP 24-54)**

2.5 Medicaid Enrollment as a Ventilator Dependent Care Unit (VDCU) and Additional VDCU Beds

Medicaid approval or denial of Medicaid enrollment as a VDCU and applications to increase the number of VDCU beds is based on Medicaid policies in the Dual Certification and the Criteria for Evaluation of Medicaid Bed Certification Applications sections of this appendix. In addition, VDCU applications will be coordinated with LARA-BCHS, Health Facility Licensing, Permits and Support Division.

2.6 Medicaid Provider Enrollment

To enroll with Medicaid, a nursing facility must:

- Receive CON approval of the beds (new providers and CHOW).
- Receive written notice from the SMA approving the Medicaid bed certifications.
- Complete a New Provider Information Packet to establish data with the RARSS. (A New Provider Information Packet may be obtained from RARSS or the MDHHS website. Refer to the Directory Appendix for contact and website information.)
- Complete the on-line CHAMPS Provider Enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information.)

A provider will not be enrolled with Medicaid until all of the above requirements are met.

NOTE: The provider's employer identification or tax identification number (EIN/TIN) registered with the Vendor Registration System must agree with the EIN/TIN on file with the RARSS and in the nursing facility enrollment information in the CHAMPS Provider Enrollment system.

2.7 Notification Process for Regulatory Actions

MDHHS or CMS may make decisions that result in the loss or reduction of a provider's Medicaid-certified beds. Loss of certification, or de-certification, means that Medicaid will no longer pay for any service in the nursing facility related to the de-certified beds.

MDHHS or its designee notifies the following entities, in writing, of the loss of Medicaid certification at least 30 days prior to the effective date of payment termination:

- The affected nursing facility,
- The local MDHHS office, and
- The public by means of public notice in a local newspaper.

This notification of the nursing facility's loss of certification will state that residents must either:

- Make other arrangements for payment to the nursing facility; or
- Relocate to a setting that is Medicaid certified.

The provider may request assistance from MDHHS to coordinate relocation for those beneficiaries who wish to transfer. MDHHS may choose to apply the Nursing Facility Closure Protocol described in the Nursing Facility Closure Protocol subsection to protect the best interests of residents faced with transfer.

2.8 Nursing Facility Closure Protocol

An interagency agreement exists between MDHHS and LARA to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, the nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.

2.9 Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure

A provider may choose to close voluntarily, not as a result of regulatory action. A provider may also choose to continue operating as a nursing facility, but withdraw from participation in the Medicaid Program. In both situations, the nursing facility must follow established guidelines to assure safe and appropriate care of residents.

When a provider decides to close voluntarily, the administrator of the nursing facility must provide written notification prior to the impending closure to the:

- State Survey Agency (SSA),
- State Medicaid Agency (SMA) /Long Term Care Policy Section,

- LTC Ombudsman,
- Residents of the nursing facility, and
- Legal representatives of such residents or other responsible parties.

Written notice must be provided at least 60 days before the date of closure. Note: In cases where the Secretary of the U.S. Department of Health & Human Services (HHS) terminates the facility's participation in either the Medicare and/or Medicaid programs, notice must be provided no later than the date that the Secretary of the U.S. Department of Health & Human Services (HHS) determines appropriate for such notification.

This 60-day notice requirement begins before any attempt to transfer a resident out of the facility in anticipation of a facility closure/withdrawal. The provider must ensure that no new residents are admitted on or after the date on which such written notification is submitted.

The written notice of a voluntary closure must include the plan for closure. The plan must be approved by the SSA and the SMA/Long Term Care Policy Section prior to notification of residents of the closure. The plan must outline the transfer and adequate relocation of residents that assures placement in the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

Upon approval of the plan by the SSA and the SMA/ Long Term Care Policy Section, actual notice of closure must be given, which means that the notice must be given to the resident and a family member or legal representative in a form that they can understand and must be explained to them as needed. The notice must include the plan as approved by the State for the transfer and adequate relocation of the residents by the date specified by the State prior to closure. It must also include assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, including home or community-based settings, taking into consideration the needs, choice, and best interests of each resident. The notice must include contact information for the LTC Ombudsman and the Area Agency on Aging.

In the event of a voluntary closure, the nursing facility remains Medicaid-certified until all residents are relocated.

If the nursing facility chooses to withdraw from Medicaid but remain open as a licensed nursing facility, residents who are Medicaid eligible at the time of facility disenrollment may remain in the facility and receive Medicaid payment. The nursing facility's Medicaid enrollment will continue for purposes of payment for state plan services as long as Medicaid residents remain in the facility.

The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix addresses voluntary closures as well as regulatory closures, and outlines the responsibilities of the state agencies involved. The SSA monitors the withdrawal or closure of a nursing facility. The provider may request MDHHS assistance with resident relocation if needed.

If the provider does not fulfill their responsibilities for the safe and appropriate relocation of residents, as reported by the SSA, the State Closure Team may change the closure into a regulatory action. At that point, the closure becomes non-voluntary and the State Closure Team may request the assistance of a closure agent or take other measures to ensure a safe and orderly transfer of residents. The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix would apply.

2.10 Nursing Facility Filing of Bankruptcy

Medicaid-enrolled providers are required to notify the MDHHS Long Term Care Operations section manager and the RARSS manager immediately upon filing for bankruptcy. (Refer to the Directory Appendix for contact information.)

2.11 Re-entry After De-certification

A nursing facility may re-enter the Medicaid Program after decertification (whether voluntary or involuntary) if the following conditions are met:

- Submission of a request to the SSA for re-entry, including documentation indicating that the factors leading to a regulatory termination no longer exist.
- Evidence that all of the applicable statutory and regulatory requirements have been met.
- There is reasonable assurance that the deficiencies that caused the regulatory termination will not reoccur.
- The facility is concurrently pursuing Medicare certification.
- The facility meets all enrollment criteria outlined in this section.

Upon re-entry into the Medicaid Program, all Medicaid beds must also be Medicare certified.

The process for re-entering the Medicaid Program includes:

ACTION	DESCRIPTION OF PROCESS
Application	The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and the SMA for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Bed Certification Applications apply as outlined in this section.
Departmental Review	The SMA makes a formal review of the nursing facility's financial status and requests confirmation of compliance with all civil rights requirements from the Office of Civil Rights (OCR). If financial responsibility and compliance with the civil rights requirements are confirmed, a reasonable assurance period (not subject to appeal) is set and the SSA is asked to conduct an initial survey.

ACTION	DESCRIPTION OF PROCESS
Survey Activity	There will be at least two surveys during the reasonable assurance period. ▪ **Initial Survey** - A survey is conducted at the beginning of the reasonable assurance period to document compliance with previously cited deficiencies. The initial survey may be a partial or full survey at the discretion of LARA. A finding of substantial compliance at this survey will allow the nursing facility to begin the reasonable assurance period. If the nursing facility is found to not be in substantial compliance, then it must re-apply. ▪ **Second Survey** - A full survey must be conducted and the nursing facility must be in substantial compliance in order for the reasonable assurance period to end. The SSA will schedule the survey to coincide with the end of the established reasonable assurance period. If the nursing facility has maintained compliance during the reasonable assurance period, it may be approved for Medicaid enrollment. If the nursing facility is not in substantial compliance at the second survey, it must enter another reasonable assurance period if it continues to seek re-entry into Medicaid. ▪ **General Survey Protocol** - Facilities are afforded the same rights for challenging survey results as in the standard certification process, which is through the administrative review process within the SSA. During the reasonable assurance period, the SSA may conduct as many surveys as approved by Medicaid to document compliance with state and federal requirements. Surveys are unannounced; therefore, the nursing facility will only receive acknowledgement of receipt of the approved application and that Medicaid enrollment is based on the outcomes of the surveys conducted. All survey reports (CMS-2567L) are forwarded to the SMA within 10 working days to determine the significance of any findings and the resultant action plan. The results of each survey are evaluated to ensure that the reasons for the termination no longer exist or are at the level of substantial compliance (Level One – Cells A, B or C). Facilities are notified of the determination, in writing, by the SMA. If the SSA determines that the conditions for re-entry are met, Medicaid enrollment will be approved. If the SSA determines that the conditions for re-entry have not been met, the SSA will send the provider a denial letter. The nursing facility may correct the deficiencies and re-apply for certification, resulting in another reasonable assurance period.

ACTION	DESCRIPTION OF PROCESS
Reasonable Assurance Period	The reasonable assurance period is designed to assure that a nursing facility can operate for a certain period of time without the re-occurrence of the deficiencies that led to termination from participation in the program(s). The SMA contacts the SSA to conduct surveys during the reasonable assurance period. The reasonable assurance period begins when the initial survey is completed, which assures LARA that the nursing facility is complying with requirements for which they were originally de-certified. The SMA will establish a reasonable assurance period, typically from one to six months duration. The length of the reasonable assurance period is not subject to appeal. The time frame for reasonable assurance is based upon criteria, which may include: ▪ A history of maintaining compliance ▪ Absence of a pattern of repeat citations ▪ Timely submission of plans of correction and implementation of approved plans of correction when needed ▪ Number of adverse actions initiated in the past three years ▪ History of termination and re-admission to the program ▪ Current compliance status ▪ Existence of other factors that may affect compliance, e.g., staffing concerns, turnover of key personnel, pay scale
	The SMA will not approve Medicaid enrollment until the reasonable assurance period has been satisfied. During the reasonable assurance period, the nursing facility must: ▪ Employ adequate management and care staff to provide care in accordance with all applicable federal, state and local regulations. ▪ Limit admissions to two residents per day or four residents in a seven-day period, regardless of payment source. ▪ Develop an admissions informed consent document that is acceptable to the SMA and that explains the re-entry process. The document should further explain to the resident (or authorized representative) that their residency in the nursing facility could be temporary and a transfer to another setting may be necessary if the nursing facility fails to meet all of the requirements for certification. This notice must be explained to, and signed by, the resident or their authorized representative. A signed copy of this document must be placed in the resident's record.
Appeals Procedure	An applicant may appeal a denial of Medicaid enrollment by submitting a written request within 60 days of the date of the denial decision. The appeal should be addressed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.) The written appeal must include documentation to support the appeal. If the applicant fails to submit documentation within the 60 days, then the denial decision remains in effect.

ACTION	DESCRIPTION OF PROCESS
Payment	Providers are eligible for Medicaid reimbursement when the nursing facility has been found to meet the conditions for re-entry and is an enrolled Medicaid provider. Under extraordinary circumstances, the SMA may elect to enter into a provisional Medicaid provider agreement during the reasonable assurance period. In most cases, Medicaid reimbursement is not available until the facility has met all required conditions.

2.12 Non-available Beds

Any nursing facility bed is considered available for occupancy if the bed is licensed and Medicaid certified, unless it is removed from service due to a regulatory ban on admissions or removed voluntarily using the SMA's non-available bed policy.

The SMA allows nursing facilities to designate beds as non-available, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Cost Reporting & Reimbursement Appendix of this chapter.

SECTION 3 - STAFF CERTIFICATION

All health care professionals performing duties within Medicaid-certified nursing facilities must possess the licensure and certification credentials required for their individual disciplines.

3.1 NURSE AIDE CERTIFICATION AND TRAINING

A nurse aide employed in a Medicaid-certified nursing facility must be a Certified Nurse Aide (CNA). Medicaid reimburses facilities through the annual cost settlement process for the Medicaid share of documented costs directly related to meeting the nurse aide training and testing requirements. Training programs and testing sites must be approved by the SSA in order for those costs to be reimbursed by Medicaid. A nursing facility may not charge its employed aides for training, testing, and registry costs related to meeting these requirements. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

The SSA is responsible for approval of programs that train and certify nurse aides for employment in all Medicaid-certified nursing facilities.

- For information about training requirements, programs or facilities, or concerns regarding the testing program or information placed on the Nurse Aide Registry, contact the LARA Bureau of Community and Health Systems.
- For testing registration information or assistance, or test site concerns, contact the LARA BCHS Nurse Aide Section or refer to their website.
- To inquire about a nurse aide's listing on the Registry, name and good standing, contact the LARA BCHS Nurse Aide Section or refer to their website.

(Refer to the Directory Appendix for contact information.)

3.2 EMPLOYEE SCREENING (CRIMINAL BACKGROUND CHECKS)

Nursing facilities are prohibited from employing, independently contracting with, or granting clinical privileges to any individual making application or being offered privileges who has been convicted of certain crimes. Michigan Public Act 28 of 2006 requires nursing facilities to facilitate and bear the cost of criminal background checks, either through the Michigan State Police or the Federal Bureau of Investigation (depending on defined criteria), on all individuals seeking to perform direct services to residents. The law also provides for the sharing of criminal background information with other member agencies of the provider community for the purpose of applicant screening.

An overview of Michigan Public Act 28 of 2006 and template forms for use by nursing facilities conducting criminal history checks on applicants are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 4 - NURSING FACILITY SURVEY

The purpose of surveying nursing facilities in the State of Michigan is to ensure quality of life and quality of care for residents. In order to fully comply with the applicable federal and state statutes, the SMA has contracted with the SSA to conduct nursing facility certification surveys. This contract represents the intent and purpose of both agencies to promote high quality health care and services for beneficiaries under the Medicaid Program to:

- comply with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration of the Medicaid Program and certification of health care providers;
- assure that the services provided under Title XIX and Title V of the Social Security Act are consistent with the needs of beneficiaries and the programs' objectives and requirements.

Reports generated as a function of this process are used by MDHHS to assure proper payment of claims submitted, to facilitate enforcement actions, and to assess continued certification under the current Medicaid enrollment.

4.1 SURVEY PROCESS

The basic survey protocol, including criteria and procedures, is the same for participation in both the Medicaid and Medicare Programs. The SSA:

- At appropriate intervals as prescribed by federal and state regulations, conducts on-site surveys, re-surveys and other necessary monitoring of the providers applying to or already participating in the Medicaid Program to determine compliance with program requirements.
- Recommends to the SMA certification of those providers that meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification complies with applicable statutes, regulations, the provisions of the intra-agency agreement and is subject to review and comment by the SMA.
- Notifies the SMA and the individual provider within five working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both agencies and shall include information sufficient in detail to allow Medicaid to carry out appropriate provider agreement action. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
- Annually provides to Medicaid a complete listing of all certifications in effect on January 1st of that year.
- Determines and authorizes any waiver of provider requirements granted, the conditions of the waiver, and the time period such waiver will be in effect.

4.2 Survey Review

The SSA sends all survey reports with enforcement recommendations to the SMA for review. Reports and subsequent enforcement recommendations include information sufficient in detail to allow the SMA to carry out appropriate provider agreement action. Following review and authorization by the SMA, the SSA may be designated to generate any or all of the necessary certification and enforcement documentation pertaining to a participating provider.

SECTION 5 - NURSING FACILITY ENFORCEMENT

This enforcement policy applies when the State Survey Agency (SSA) or the Centers for Medicare & Medicaid Services (CMS) determines, on the basis of a standard, abbreviated, extended, or partial extended survey, that a provider is or was out of compliance with the federal certification requirements as stated in 42 CFR Part 488, Survey, Certification and Enforcement Procedures. In Michigan, the LARA Bureau of Survey and Certification (BSC) functions as the SSA.

5.1 AUTHORITY

The Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended, incorporated specific provisions for nursing home reform into the Social Security Act, including revised requirements for survey, certification, and enforcement of providers participating in the Medicare and Medicaid programs. Applicable regulations are found at 42 CFR Part 488.

5.2 GUIDING PRINCIPLES OF ENFORCEMENT

5.2.A. PHILOSOPHY

- All long term care providers have the **responsibility** to provide person-centered quality care and services appropriate to the needs of the residents they serve.
- Long term care providers are an essential **resource** for communities, providing health care services, education, and employment.
- LARA, as the licensing and certification authority, must ensure that all Michigan long term care providers fulfill their responsibility to provide **quality** services.

5.2.B. PURPOSE

To develop, implement, and support an enforcement system that:

- **Promotes** continuous provision of quality care and the highest practicable physical, mental and psychosocial functioning of each resident.
- **Protects** the health, welfare, rights, and choices of long term care residents, as defined by law and regulation, without infringing upon the rights of the resident.
- **Promptly corrects** noncompliance through effective application of appropriate regulatory remedies.

5.3 ENFORCEMENT PRINCIPLES

- The enforcement system must reflect a philosophy of serving resident needs by providing quality care.

- The SSA and the SMA must both strive for consistency in identifying deficiencies and in decision-making for selection and application of remedies. This enforcement principle is consistent with the intent of federal enforcement regulations, the State Operations Manual, and the CMS evaluation process for SSA performance.
- The SMA's enforcement plan contains a range of remedies. This allows an appropriate remedy scheme tailored to the facility and the cited deficiencies.
- Repeat noncompliance or failure to obtain compliance will result in the application of progressively stronger remedies.
- Remedies that displace residents from their homes will only be used as a last resort; such remedies include facility closure, termination of Medicaid or Medicare provider agreements, or transfer of residents. These remedies will not be used unless the health, safety and/or welfare of the residents is seriously affected, other remedies have not resulted in the facility's ability to achieve and maintain substantial compliance, and/or the physical plant is not a viable setting for quality care and services.
- State enforcement remedies for nursing facilities must include, at a minimum, statutorily specified remedies for skilled nursing facilities and may include additional or alternative remedies approved by CMS.

5.4 Facility Compliance and Deficient Practice

The SSA or CMS, on the basis of a standard, abbreviated, extended or partial extended survey, will determine whether a participating provider is in compliance with the federal regulations governing Medicaid certification. Based on this determination, one or more remedies (corrective actions) may be selected based on the seriousness of the deficiency, facility history, welfare of the residents, and the likelihood that the remedy will promote prompt and sustained compliance. Enforcement remedies include both federal and state enforcement options. Criteria have been designed to minimize the time between identification of the deficiencies and application of remedies. Repeated or uncorrected deficiencies will be assessed progressively stronger remedies. If the SSA finds that a provider currently meets the requirements, but previously was noncompliant, the SSA may impose a remedy for the days it finds that the facility was not in compliance. Nothing in this paragraph shall be construed as restricting the remedies available to the LARA to address a nursing facility's deficiencies.

5.5 Determining the Seriousness of Deficiencies

To determine the seriousness of deficiencies for the purpose of selecting enforcement remedies, LARA will consider the factors of scope and severity. Scope represents how much of the facility, or how many residents, are or may be affected by a specific deficient practice. Severity represents the potential for harm, or the level of harm that has occurred. Scope and severity are assigned an alphabetic and numeric level on the remedy determination grid. The most serious deficiency cited (based on level of scope and severity) determines the category or categories of remedies to be applied. Other factors in the selection of remedies include:

- whether the deficiencies immediately jeopardize the health, safety, or welfare of the facility's residents
- the relationship of one deficiency to other deficiencies
- the facility's compliance history

- the likelihood that the selected remedy will promote correction and continued compliance
- the provider's culpability, i.e., whether noncompliance is the result of neglect, indifference or disregard
- the relationship of one remedy to other remedies

5.5.A. Severity

LEVEL OF SEVERITY	DEFINITION
No actual harm with a potential for minimal harm	The deficiency has the potential for causing no more than a minor negative impact on the resident(s).
No actual harm with a potential for more than minimal harm, but not Immediate Jeopardy	Noncompliance that results in minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach their highest practicable physical, mental and psychosocial wellbeing as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Actual harm that is not Immediate Jeopardy	Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach their highest practicable physical, mental, and psychosocial wellbeing as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Immediate jeopardy to resident health or safety	A situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility.

5.5.B. Scope

SCOPE OF IMPACT	DEFINITION
Isolated	Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
Pattern	Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) has been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.
Widespread	Scope is widespread when the problems causing the deficiencies are pervasive in the facility or represent systemic failure.

5.6 Enforcement Remedies

A remedy is a corrective action. Remedies available to LARA are specified in federal and state law. When the scope and severity increase, the deficiencies repeat, or the facility fails to maintain substantial compliance, selected remedies may also increase.

5.6.A. Federal Enforcement Remedies

Each federal remedy listed below is described in rules as stated in 42 CFR Part 488 et. seq., and further discussed in the CMS State Operations Manual for Medicaid and/or Medicare certified facilities. Federal remedies available to LARA or CMS include, but are not limited to:

- Denial of payment for new Medicare and/or Medicaid admissions
- State monitoring
- Temporary management
- Directed plan of correction
- Directed inservice training
- Civil money penalties
- Transfer of residents
- Closure of facility with transfer of residents
- Termination of Medicaid enrollment
- Denial of payment for all Medicare and/or Medicaid residents imposed by CMS
- Alternative or specified state remedies approved by CMS
- Administrative/Clinical Advisor

5.6.B. State Enforcement Remedies

The SSA has the option of imposing any state or federal remedy based on the facility's failure to maintain compliance, deficiencies cited within the same regulatory grouping that repeat within the last 24 months (or two standard survey cycles), and the degree of culpability of the facility. In addition to federal remedies, the SMA may accept one or more of the following enforcement actions taken by the SSA under state licensure authority. Also see Michigan Enforcement Rules for Long Term Care Facilities at R 330.11001-330.11017.

- Emergency Order Limiting, Suspending or Revoking a License
- Notice of Intent to Revoke Licensure
- Correction Notice to Ban Admissions or Readmissions
- Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements
- Appointment of a Temporary Manager or Clinical/Administrative Advisor
- State Patient Rights Penalties, if applicable

5.7 Denial of Payment for New Admissions (DPNA)

Denial of payment for new admissions may be imposed at any time a provider is not in substantial compliance and must be imposed when a provider is not in substantial compliance within three months of being found out of compliance.

The DPNA enforcement remedy stops Medicaid payment for any new residents admitted to the facility after the effective date of the DPNA. The resident's status on the effective date of the denial of payment is the controlling factor in determining whether readmitted residents are subject to the denial of payment.

Guidelines for the definition of new admission are:

- Medicaid residents admitted to the facility on or after the effective date of the denial of payment for new admissions are considered new admissions. If Medicaid residents are discharged and readmitted to the facility, they continue to be considered new admissions, and are subject to the denial of payment.
- Medicaid residents admitted to the facility and discharged before the effective date of the DPNA are considered new admissions if they are readmitted to the facility on or after the effective date of the DPNA. Therefore, they are subject to the denial of payment.
- Medicaid residents admitted before the DPNA and discharged on or after the effective date of the DPNA are not considered new admissions if subsequently readmitted. Therefore, they are not subject to the denial of payment.
- Medicaid residents admitted before the effective date of the DPNA who take temporary leave before, on, or after the effective date of the DPNA are not considered new admissions upon return and, therefore, are not subject to the denial of payment.
- Medicaid residents admitted on or after the effective date of the DPNA who take temporary leave (e.g., hospital or therapeutic leave) are not considered new admissions when they return. If they were subject to the DPNA before their leave, they continue to be subject to it after their return.
- Private pay residents admitted to the facility after the effective date of the DPNA who then become eligible for Medicaid are subject to the denial of payment.
- Private pay residents in the facility prior to the effective date of the DPNA who then become eligible for Medicaid after the effective date of the DPNA are not subject to the denial of payment.

5.8 Recovery of Medicaid Funds for Admissions During DPNA

Under federal regulations, no federal funds will be paid to a nursing facility or to a state for any resident admitted when the facility is under a Denial of Payment for New Admissions sanction. Nursing facilities will be subject to Medicaid post-payment review to determine if any new residents were admitted during a period of time when the facility was under a DPNA sanction and, if so, Medicaid funds will be recovered from the facility. Facilities will be notified in advance of any recovery action and given the opportunity to produce documentation indicating that the admission was not a new resident and/or to appeal the MDHHS determination.

5.9 Minimum Data Set - Resident Assessment Instrument

A nursing facility is required to submit resident assessments to the QIES ASAP system using the Medicare Data Communication Network (MDCN). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B). Failure to comply will result in citations and imposition of remedies, including requirement of a plan of correction. Continued failure to comply will result in increasingly severe remedies up to and including termination of Medicaid enrollment.

An individual who willfully and knowingly certifies a material and false statement in a resident assessment will be subject to civil money penalty fines as outlined in 42 CFR § 483.20(f)(5)(j)(1).

5.10 Termination

This remedy may be imposed at any time when appropriate, but must be imposed when a provider has been out of substantial compliance for six months.

5.11 Purpose of Remedies

TYPE OF REMEDY	PURPOSE
Directed Plan of Correction	The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements. It is used when specific corrective action is required or the corrective action must be accomplished within a specified time, e.g., when a facility's heating system fails and specific repairs or replacement must be made within a specific period of time; when a provider has had difficulty attaining compliance after a revisit; or when assistance with a plan of correction is needed to ensure an effective revisit prior to imposition of a denial of payment or termination of provider status.
Directed In-Service Training	The purpose of directed in-service training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements. Directed in-service training is used when education is likely to correct deficiencies and help the provider achieve substantial compliance.
State Monitoring	The purpose of state monitoring is to oversee correction of cited deficiencies as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring must be used if the provider has had three consecutive standard health surveys with substandard quality of care; poor compliance history, pattern of poor quality of care, and/or many complaints; immediate jeopardy without a temporary manager appointment; concern that conditions in a facility have potential to worsen; the provider refuses to accept appointment of a temporary manager; the provider is unwilling or unable to take corrective action for cited substandard quality of care. LARA BSC, with CMS approval, may impose state monitoring without notice.
Denial of Payment for New Admissions	The purpose of Denial of Payment for New Admissions (DPNA) is to encourage prompt and sustained compliance. DPNA may be imposed any time the provider is found out of substantial compliance and must be imposed when a provider is out of compliance three months after a determination of noncompliance. DPNA may be imposed alone or in combination with other remedies.

TYPE OF REMEDY	PURPOSE
Denial of Payment for All Medicare and Medicaid Residents	The purpose of Denial of Payment for All Medicare and Medicaid Residents is to encourage prompt and sustained compliance. This remedy may be imposed any time the provider is out of substantial compliance, but only by CMS. Factors considered in imposing this remedy include the seriousness of current survey findings, noncompliance history of the facility, and failure of other remedies to achieve or sustain compliance.
Temporary Management	The purpose of a temporary manager is to oversee correction of deficiencies and ensure the health and safety of the facility's residents while corrections are being made. A temporary manager may be imposed as a federal remedy any time a provider is not in substantial compliance; when a facility's deficiencies constitute immediate jeopardy or widespread actual harm and is imposed as an alternative to termination; or to oversee the orderly closure of a facility. The authority and qualifications of the temporary manager are described in the State Operations Manual at Section 7550.
Temporary Administrative and/or Clinical Advisor	The purpose of a Temporary Administrative and/or Clinical Advisor is to monitor and mentor the facility administrative and/or clinical staff through the period of corrective action. This is an additional federal Category 2 enforcement remedy defined in the State Plan and MDHHS Rule 330.11007(6). Authority for this remedy is found at §488.303(e) and §488.406(a)(8)&(9).

5.12 Revisit Policy

Revisits are not assured and, depending on the circumstances of any given situation, termination can occur any time for any level of facility noncompliance without regard to revisits. Facilities have the responsibility to correct their deficiencies and notify the SSA when corrections will be completed. It is expected that revisit requests will be made prudently so that the likelihood of additional revisits is reduced. If correction is not achieved at the expected time, the facility should notify the SSA that correction has been delayed so that the revisit can be delayed. LARA's expectation is that the facility has achieved compliance status as alleged in the Plan of Correction. Revisits may be conducted for any level of noncompliance. Remedies may be imposed for any level of noncompliance. Revisits are not assured before imposition of denial of payment for new admissions or termination.

The SSA is authorized, at its discretion, to perform up to three revisits to verify compliance. A fourth revisit may be conducted by the SSA only with the authorization of the SMA. An approved Plan of Correction must be received by the SSA with each revisit request. A fourth revisit requires justification.

5.13 Choosing the Compliance Date

LARA follows CMS policy related to revisits. On any revisit, the compliance date is the accepted Plan of Correction completion date if it is determined at the time of the revisit that the deficiencies were corrected and the facility is in substantial compliance. If a revisit survey identifies that the facility had a deficiency after the completion date that was corrected before the revisit date, the actual correction date is used.

5.14 Evidence of Compliance in Lieu of a Revisit

Revisits may be conducted at any time for any level of noncompliance. Revisits are required whenever a survey finds noncompliance at Level F (Substandard Quality of Care), Harm, or Immediate Jeopardy (IJ)

and must continue for all citations at that level until compliance is achieved with F (SQC), Harm, or IJ citations. In other cases, appropriate to the type of deficiency, acceptable evidence of compliance may be allowed in lieu of a revisit at the SSA's discretion. Evidence of compliance is not acceptable after a second revisit has been conducted within an enforcement cycle. When a facility is allowed to present acceptable evidence in lieu of a revisit, the compliance date is the date the evidence indicates the facility was in substantial compliance.

5.15 Setting the Mandatory Three- and Six-Month Remedy Time Frames

The three-month mandatory denial of payment for new admissions and the six-month mandatory termination dates will be set based on full months rather than on a number of days. With few exceptions, these dates will coincide with the same numerical date of the month of survey exit that identified the noncompliance. For example, if a survey ended on 1/15, the three-month effective date for mandatory denial of payment for new admissions is 4/15, and the six-month termination date is 7/15. Exceptions involve those cases for which a three-month or six-month numerical date is not on the calendar. In these cases, the effective date of the remedy will be the next calendar day.

Immediate Jeopardy situations generally have 23-day termination cycles.

5.16 Failure to Readmit a Qualified Medicaid Resident

A daily civil money penalty (CMP) of $400 will be imposed when an enrolled Medicaid facility refuses to readmit a qualified Medicaid resident (as defined by CMS) following hospitalization. An opportunity to correct will not be provided. This daily CMP will start on the date validated by LARA that nursing home readmission should have occurred. The daily $400 CMP continues until the resident is offered the next qualifying available Medicaid bed at the refusing facility, or the resident is placed in another suitable facility. The refusing facility will be notified by the SSA when an allegation of failure to readmit a qualified Medicaid resident is being investigated.

5.17 Definitions

TERM	DEFINITION
Administrative and/or Clinical Advisor	An alternative federal Category 2 remedy imposed upon a facility for the purpose of mentoring facility administrative and/or clinical staff through the period of corrective action.
Ban on Admissions	Admissions to the facility are suspended on the date specified in the LARA Correction Notice Order. Includes readmissions if stated in the order.
CMS	The Centers for Medicare & Medicaid Services.
Culpability	The extent to which the facility is responsible for the cited deficient practice. This is often related to occasions when the noncompliance is determined by the SSA to be intentional, or a product of neglect, indifference, or disregard.
Deficiency	A facility's failure to meet any participation requirement specified in the Social Security Act or in 42 CFR, Subpart B, 483.5 - 485.75.
Failure to Maintain Compliance	Inability of the facility to maintain substantial compliance for at least three months, or a facility having three or more survey cycles in a 12-consecutive month period.

TERM	DEFINITION
Immediate Jeopardy	Immediate Jeopardy to resident health or safety means a situation in which immediate corrective action is necessary because the nursing facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility. Such a finding is made in accordance with the criteria and definitions in the CMS State Operations Manual Appendix Q - Guidelines For Determining Immediate Jeopardy.
Noncompliance	Any deficiency that causes a facility to not be in substantial compliance.
No Opportunity to Correct	The facility will have remedies imposed immediately after a determination of noncompliance has been made.
Opportunity to Correct	The facility is allowed an opportunity to correct identified deficiencies before remedies are imposed.
Past Noncompliance	Past noncompliance is noncompliance that occurred between two certifications of compliance, against which a civil money penalty is imposed. If past noncompliance is cited, a civil money penalty must be imposed.
Plan of Correction (POC)	Mandatory for all deficiencies of scope and severity levels B through L on the remedy determination grid. A POC must be provided to the SSA within 10 days of the receipt of the survey report (CMS-2567). The POC must be approved by the SSA; if disapproved, remedies may be imposed immediately.
Remedy	A corrective action. Some remedies are specified in federal law; others are specified in state law.
Repeat Deficiency	When deficiencies in the same regulatory grouping of requirements are found more than once within 24 months or two standard survey cycles.
Repeated Noncompliance	For purposes of enforcement action, this term refers to findings of Substandard Quality of Care on three (3) consecutive standard surveys but does not refer to citations in which the substance of a deficiency or the exact tag number of a deficiency is repeated.
Substandard Quality of Care	Deficiencies at 42 CFR 483.13 (Resident Behavior and Facility Practices, F tags 221-226); 483.15 (Quality of Life, F tags 240-258); or 483.25 (Quality of Care, F tags 309-333) on the remedy determination grid in cells F, H, I, J, K, or L.
Substantial Compliance	Survey findings or acceptable evidence of compliance in lieu of revisit indicate that no actual harm has occurred and there is a potential for no more than minimal harm.

5.18 SUBSTANDARD QUALITY OF CARE (SQC)

When a standard or abbreviated survey identifies substandard quality of care (SQC), an extended or partial extended survey is conducted. In addition to the imposition of remedies, the SSA takes the following actions:

- Notifies the attending physicians of residents identified during the survey process as having been affected by the substandard quality of care.

- Notifies the state licensure board responsible for licensing the facility's administrator of all findings of substandard quality of care.
- Prohibits the facility from providing nurse aide training and competency evaluation programs for two years.

If a facility has been found to have provided SQC on the last three (3) consecutive standard surveys, along with other remedies, LARA will impose:

- Mandatory denial of payment for new admissions;
- State monitoring.

5.19 Immediate Jeopardy [Changes Made 4/1/2025]

When the SSA identifies that Immediate Jeopardy to resident health or safety exists, the provider is notified and directed to submit as soon as possible an allegation that the Immediate Jeopardy has been removed. Within two calendar days of the last day of the survey during which Immediate Jeopardy was identified, the SSA will notify the provider that the SMA must terminate Medicaid enrollment within 23 calendar days of the last day of survey if the Immediate Jeopardy has not been removed. At its discretion, the SMA may appoint a temporary manager who must remove the Immediate Jeopardy within 23 days to avoid termination.

In order for a 23-day termination timeclock to be stopped, the provider must submit an acceptable Plan of Correction to the SSA. A subsequent revisit must then be conducted to verify removal of the Immediate Jeopardy, even if the underlying deficiencies have not been fully corrected.

Adjusted annually, Civil Money Penalties (CMP) of $3,050 to $10,000 per day will be imposed for each day an Immediate Jeopardy was identified before removal. Following removal of the Immediate Jeopardy, CMPs will continue until the facility is found to be in substantial compliance but will be selected from a lower fine range of $50 to $3,000 per day. The upper range of CMPs will apply for a minimum of one day, even if the Immediate Jeopardy is removed immediately after identification and notification. No CMP will apply on the day the facility is determined to be in substantial compliance.

The SSA may consider using a Per Instance Civil Money Penalty of $1,000 to $10,000, adjusted annually, when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g., a discretionary denial of payment for new admissions, directed plan of correction, or directed in-service training.

Pursuant to 42 CFR §488.430(a), multiple per instance CMPs may be imposed for the same type of noncompliance and per instance CMPs (PI-CMPs) and per day CMPs (PD-CMPs) to be imposed on the same survey. **(text added 4/1/2025)**

5.20 No Opportunity to Correct

Providers will not be given an opportunity to correct deficiencies before remedies are imposed when they have deficiencies of actual harm (or higher) on the current survey event, as well as on the previous standard survey or any intervening survey. The previous harm (or higher) level deficiency must have been in a completed survey cycle with compliance verified. LARA will impose either a Civil Money Penalty or Denial of Payment for New Admissions, or both. LARA may impose other optional federal remedies.

5.21 Opportunity to Correct [Change Made 4/1/2025]

An opportunity to correct deficiencies before remedies are imposed is not assured. The SSA has no obligation to give a provider an opportunity to correct deficiencies prior to imposing remedies and must only meet the minimum notice requirements that are applicable to the imposition of remedies. At the SSA's discretion, it may provide facilities an opportunity to correct deficiencies before remedies are imposed when they do not meet the criteria for "No Opportunity to Correct."

When an opportunity to correct deficiencies before remedies are imposed is offered, the SSA will request an acceptable plan of correction, provide initial notice of possible enforcement action, conduct a revisit (if applicable), and provide formal notice of other remedies if noncompliance continues at revisit. While formal notice of denial of payment for new admissions is generally provided in the first revisit letter, the SSA may provide it to the facility in the initial deficiency notice.

LARA must impose DPNA no later than three months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

LARA may impose a per day Civil Money Penalty, a per instance Civil Money Penalty, or both **(revised 4/1/2025)** for past noncompliance, for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by LARA based on facility history, repeating deficiencies, high numbers of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance, and for increasing noncompliance.

5.22 Prohibition of Approval of Nurse Aide Training and Competency Evaluation Programs

Federal law, as specified in the Social Security Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. Exceptions to this, as specified in Public Law 105-15, Permitting Waiver of Prohibition of Offering Nurse Aide Training and Competency Evaluation Programs in Certain Facilities, will apply.

5.23 New Owner

A new owner may apply to the SSA to have approval of the facility's nurse aide training and competency evaluation program restored before a two-year lockout period has expired.

5.24 Notice of CMP Assessment

Prior notice is not required before the imposition of CMPs. A penalty equivalent to a one-day penalty will apply in all circumstances even if the violation(s) is immediately corrected. The daily penalty will end on the day prior to the determination of substantial compliance, or on the day prior to the determination that a civil money penalty is no longer warranted. The SSA determines compliance. CMP amounts may be increased to reflect changes in levels of noncompliance at revisit. CMP amounts may increase for repeat deficiencies.

The SSA has developed a CMP schedule for Immediate Jeopardy and Harm or Potential Harm occurrences to promote a consistent application of penalties. The CMP schedule conforms to 42 CFR 488.408 and is intended to cover the majority of cases of CMP imposition. Situations may occur that justify exception to the guidelines. The CMP schedule is subject to change without notice. For further information, contact LARA Bureau of Survey and Certification (BSC). (Refer to the Directory Appendix for contact information.)

Accrual of CMPs ceases when one of the following situations occurs:

- the facility is determined by the SSA to have achieved substantial compliance
- the appointment of a receiver by a circuit court
- closure of a facility
- appointment of a temporary manager for the purpose of overseeing the orderly closure of the facility
- termination of a provider agreement

5.25 Use of CMP Funds

Money collected by the SMA as a result of civil money penalties is held in a special fund to be applied to the protection of the health or property of residents of any nursing facility that LARA finds deficient. Money recovered by the SMA from funds due a facility (because of lack of payment of civil money penalties by the facility) is also deposited into this fund.

5.26 Cost Reporting for Remediation Expenses

Temporary manager and (limited) other remediation expenses incurred by the provider as a result of an enforcement action are a Medicaid allowable routine nursing care cost as part of the owner/administrator cost classification. Total owner/administrator compensation is subject to established program cost limitations and allowable cost principles. Civil money penalties are not allowable Medicaid costs. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

5.27 Appeal Rights

The provider is notified of appeal rights at the time of remedy imposition. Providers may only appeal the existence of a deficiency and/or the number of days considered in violation. The established daily amount of the CMP is not subject to appeal. Appeals are through MDHHS. (Refer to the Directory Appendix for contact information.)

MDHHS has developed an informal review process for resolution of disputes regarding deficiencies cited by surveyors. Information regarding this process can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

The provider is also notified of waiver rights at the time of remedy imposition. Within 60 calendar days of the notice of appeal rights, the provider may elect to waive the right to appeal. The waiver must be in writing and be received by the SSA Enforcement Unit and by MOAHR within 60 days of the notice of appeal rights. Waiver of the right to appeal will reduce the total CMP amount by 35%.

5.28 Penalty Collection

Collection of civil money penalties will be made by voluntary transmittal, in a check payable to the State of Michigan, within 30 calendar days of notice of penalty amount due or within 15 days of issuance of appeal results. If voluntary transmittal does not occur, the CMP will be recovered by gross adjustment against the next available Medicaid warrant or as a component of final cost settlement in a change of ownership. No repayment schedules will be allowed for any penalty assessments. Civil money penalties are not allowable Medicaid costs.

COST REPORTING & REIMBURSEMENT APPENDIX

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SECTION 1 – INTRODUCTION

This appendix outlines Medicaid policy pertaining to nursing facility ownership, nursing facility reimbursement, nursing facility costs, and nursing facility financial reporting. Cost reporting, rate determination, financial settlement, audit, and appeal processes are addressed in this appendix. Costs classifications (such as plant, variable, allowable and non-allowable, add-ons) used to determine nursing facility reimbursement are defined.

Throughout the appendix references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration (BPHASA), is the designated SMA, and is responsible for administration of the Medicaid program. The Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Survey and Certification (BSC) is the designated SSA.

1.1 REIMBURSEMENT RATE METHODOLOGY – GENERAL

The Medicaid nursing facility reimbursement rate is prospectively determined based on the nursing facility's historical or acquisition costs, which are subject to limitations put forth in policy. Participating Medicaid providers' nursing facility resident days and cost information are reported to the SMA on an annual cost report submitted by the nursing facility. The nursing facility industry aggregate cost data is used to analyze and determine facility class reimbursement limits and related cost levels necessary for calculating nursing facility per diem rates and other analysis. The facility's routine nursing care per diem rate includes plant and variable cost based on the facility's audited allowable costs, measured against class wide rate limitations. Additional reimbursement for specific services outside of the routine nursing care per diem rate are also analyzed and determined from the facility's annual cost report and included in the Medicaid annual reimbursement settlement.

The intent of the Medicaid nursing facility reimbursement system is to:

- Assure high quality services at reasonable costs.
- Encourage the efficient use of nursing care resources.
- Provide reimbursement for allowable costs incurred by prudent, cost-conscious facility managers.
- Provide a review and appeal mechanism to assure that nursing facility providers receive fair and equitable treatment.

Reductions may be implemented to the variable cost portion of the NF rate due to Executive Order, legislative mandate, or cost savings initiatives. Notice of a reduction, or continuation of a reduction, will be issued via a policy bulletin. A record of recent NF variable rate reductions will be maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.2 MEDICARE PRINCIPLES OF REIMBURSEMENT

Unless stated otherwise in this appendix, Medicaid reimbursement rates are determined for nursing facilities in accordance with the federal Principles of Reimbursement established for the Medicare Program. Nursing facility providers are expected to comply with applicable provisions in these Principles, with policies published by the SMA, and with all relevant federal and state statutes, rules and regulations.

When reviewing the Principles of Reimbursement, any references to "intermediary" should be interpreted as referring to the SMA.

Medicare Principles of Reimbursement appear in the Code of Federal Regulations (CFR), at Title 42, Part 413, and in manuals published by the federal Centers for Medicare & Medicaid Services (CMS). The Provider Reimbursement Manual, also referred to as PRM-15 and Pub. 15, may be obtained from CMS electronically or by contacting CMS. (Refer to the Directory Appendix for website and contact information.)

SECTION 2 – DEFINITIONS

General definitions are provided in this section. More detailed explanations are provided in relevant sections related to cost, audit or rate setting.

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Acceptable Cost Report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions on the electronic format required by the SMA. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
Administrator	A nursing facility administrator is a person(s) who is on site and responsible for the professional administration, supervision and management of the nursing facility and operations as they relate to resident care. The nursing facility administrator must be licensed in accordance with the law in Michigan.
Allowable Costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare & Medicaid Services, unless stated to the contrary in policies and procedures issued by the SMA.
Ancillary Services	Services for which charges are customarily made in addition to routine service charges. Services are defined in the Coverages portion of this chapter.
Asset Acquisition Cost	The cost or value for a nursing facility asset determined in accordance with Medicare Principles of Reimbursement. Medicaid further defines acquisition cost as the cost incurred by the present owner in acquiring the asset. <u>For Class I, II, III and IV Nursing Facilities</u> For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair market value of the asset at the time of its purchase. <u>For Class III and IV Nursing Facilities</u> For depreciable assets acquired on or after December 1, 1997, the allowable historical cost of the asset may not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 or, if the asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997.
Audit	Review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid Provider Manual. An audit includes, but is not limited to, a limited-scope audit or an on-site audit.

Audit Adjustment	An adjustment to the cost report after an audit to correct items that are noncompliant with allowable cost principles or other policy contained in the Medicaid Provider Manual. Adjustments can be a direct adjustment (i.e., an adjustment only for the noncompliant item[s]), an extrapolation adjustment, or a combination of the two adjustment methods.
Audit Disallowance	See Audit Adjustment definition.
Authorized Representative	An individual who has legal authority to obligate the nursing facility entity. The individual may be an officer, senior or majority partner, possess controlling ownership interest or an appropriate management employee of the licensed nursing home business entity. For purpose of signatures required for cost reporting and reimbursement request actions, individuals not included in these positions must have designated legal right to act on behalf of the subject business entity.
Available Bed	A bed considered available for occupancy. Beds are considered available except in the following situations: ▪ Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payment for New Admissions action). ▪ Beds covered under a SMA-approved Non-Available Bed Plan. ▪ Beds temporarily unoccupied due to renovation or construction where the SSA has deemed the beds unacceptable for occupancy, for example beds which are a part of a Building Program Agreement.
Available Bed Days	The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost reporting period that they are available.
Average of Variable Costs	See Class Average of Variable Costs.
Ban on Admissions	A regulatory/enforcement sanction, imposed by the SSA, prohibiting the admission of any new resident(s) into the nursing facility, regardless of payment type, while the prohibition is in effect. Readmissions are allowed during this period on an individual case basis at the discretion of the SSA. A modified ban on admissions is a regulatory/enforcement sanction, imposed by the SSA, which may be imposed for a period of time after a ban on admissions has ended. The length of the modified ban on admissions is at the discretion of the SSA and may limit the number of new admissions for a designated period of time. Note: A Ban on Admissions is different from a Denial of Payment for New Admissions.
Base Costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers compensation; utility costs; consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as previously defined, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.

Base Costs Per Day	Facility base costs divided by the total number of resident days for the same period.
Base Cost Component, Indexed	See Indexed Base Cost Component.
Base Period	An interval of time for which cost data is obtained and used in the calculation of a prospective reimbursement rate.
Capital Expenditure	Expenditure not limited to cost of construction, engineering, and equipment, which, under Generally Accepted Accounting Principles, is not properly chargeable as an expense of operation.
Case-Mix Category	System that categorizes residents based on their clinical conditions and resource consumption into different groupings. Residents with similar clinical conditions and resource consumption are grouped into the same case-mix category.
Census	See Resident Days/Occupancy.
Census Day	A census day is counted when a resident is occupying a nursing facility bed at midnight. A census day is counted if: ▪ the resident is away from the facility for therapeutic leave and the facility is paid by any payer source to hold the bed; ▪ the resident is on a one-day stay and the nursing facility is paid for the day; ▪ the resident is discharged due to death and the nursing facility is paid for the day; ▪ the leave days (bed holds) are paid for by non-Medicaid sources; or ▪ it is a resident's day of discharge that qualifies as a late discharge by the Medicare program. A resident is counted for census purposes if the resident is admitted to the hospital, except when the facility may be reimbursed by Medicaid to hold the bed or when a Medicaid beneficiary is hospitalized and the facility is ineligible for reimbursement because it is not at 98% occupancy (unless the facility is reimbursed by another payer source to hold the bed). If a resident is hospitalized and the facility is not paid by any source to hold the bed, the day is not included in the census. A resident is counted for census purposes on the day of admission, but not on the day of discharge except as noted above.
Chain Organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
Change of Ownership (CHOW)	Any ownership change, including any sale or transfer conducted during a bankruptcy or receivership proceeding, that affects the provider/licensed operator of a nursing facility, including an exchange of real property, through either sale or lease, e.g., a sale of real estate, including a sale of a building housing a nursing facility provider as a lessee, or a change in corporate structure for a nursing facility, e.g., a change from a sole proprietorship to a corporation.
Class I Facilities	Proprietary and nonprofit nursing facilities that do not fall under the Class II, Class III, Class IV or Class V definitions.

Class II Facilities	Proprietary nursing facilities for the mentally ill or developmentally disabled (intellectual disability), with a different variable cost limit than Class I facilities.
Class III Facilities	Proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities.
Class IV Facilities	State-owned and operated institutions for individuals with intellectual disabilities (developmentally disabled), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and nonprofit nursing facilities for individuals with intellectual disabilities.
Class V Facilities	A distinct part of a special nursing facility for the care of ventilator-dependent residents.
Class VI Facilities	Hospitals that provide a program of short-term nursing care (Swing Beds) not exceeding 100 days per stay.
Class VII Facilities	State-owned and-operated veterans' homes as established under Michigan Public Act 152 of 1885.
Class Average of Variable Costs (AVC)	The total indexed variable costs for all facilities in a class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class. For example, the AVC for October 1, 2018, which is used for rate year October 1, 2018 to September 30, 2019, is based on variable costs reported in cost reports for facility fiscal years ending in 2017, indexed to October 1, 2017.
Class Variable Cost Limit (VCL)	A limit set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year. The 80th percentile is determined by rank ordering facilities from the lowest to the highest IVC, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the class are reached. The Variable Cost Limit for the class of facilities equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities. For example, the VCL for October 1, 2018, which is used for rate year October 1, 2018 through September 30, 2019, is based on variable costs reported in cost reports for facility fiscal years ending in 2017, indexed to October 1, 2017.
Common Ownership	A situation in which more than one individual possesses significant (5% or greater) ownership or equity in a nursing facility or an organization serving the nursing facility provider.
Compensation	The total monetary, fringe, and/or benefits received by an employee or owner for services rendered to the nursing facility.
Completed Audit	Issuance of the Preliminary Summary of Adjustment Notice. Completed audit includes the Exit Meeting with the nursing facility provider unless the Exit Meeting is waived.
Control	A situation where an individual or organization has the power, directly or indirectly, to significantly influence and/or direct the actions or policies of a nursing facility or an organization serving the nursing facility provider.
Corporate Official or Employee	An individual representing an organization with the authority to exercise control over a nursing facility.
Cost Center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.

Cost Index	An indicator used to adjust nursing facility cost levels. The cost index used by Medicaid is Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index is used to adjust reported costs from the facility's cost report period end date to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2018 to September 30, 2019 nursing facility rate year are indexed to October 1, 2017.
Cost Report	Reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least six Medicaid residents must be on MDHHS cost reporting forms. A nursing facility provider with fewer than six Medicaid residents per day must file a "less than complete cost report" and is not subject to audit or rate setting purposes.
Current Provider	The provider that operated the nursing facility during the period of the last cost report on which normal rate setting would occur. Also see Provider.
DEFRA	Deficit Reduction Act of 1984
Denial of Payment for New Admissions (DPNA)	A regulatory/enforcement action, imposed by the CMS or the SMA, prohibiting payment for new Medicare and/or Medicaid admissions. Medicaid will not pay for services provided to a resident admitted during a DPNA. Note: A Denial of Payment for New Admissions is different from a Ban on Admissions.
Economic Inflation Rate	The annual economic inflation percentage for Class I and Class III nursing facilities established by the state legislature through the appropriations process.
Economic Inflation Update	The Economic Inflation Rate (EIR) for the facility class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Extrapolation	An audit adjustment methodology that projects an error rate (using valid statistical procedures) for expenses reported on the cost report through the audit of statistically sampled items. The error rate will solely or partially determine the provider's audit adjustments.
Facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements.
Fair Market Value	The price that an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition, generally comparable to the price at which other sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.

Filed Cost Report	A cost report package is only considered filed when all the following conditions are met: ▪ the package is complete; ▪ the cost report calculations are mathematically accurate, reasonable, and consistent; ▪ the completed electronic cost report (ECR) data uses the required software and specified format; ▪ MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file; ▪ an electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file; ▪ the data meets a set of validation checks contained within the ECR, plus the appropriate bed size and certification reporting requirements; ▪ the submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues; and ▪ the cost report preparation complies with Medicaid policy and cost reporting instructions.
Fiscal Year - Facility	For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception. Exceptions include, but are not limited to, a change in provider ownership, fiscal period end date change, or facility relocation to a replacement facility.
Fiscal Year – State	October 1 through September 30.
Fixed Equipment (Major)	Equipment that is affixed to or constitutes a structural component of the nursing facility as defined by the current version of the American Hospital Association Chart of Accounts.
Hold A Bed Day	See Leave Day.
Home Office	The central office of a chain organization. (see Chain Organization)
Hospital Long Term Care Unit (HLTCU)	A distinct part of a general hospital licensed as a nursing facility.
Hospital Leave Day	See Leave Day - Hospital.
Indexed Base Cost Component	A facility's total per resident day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.
Indexed Support Cost Component	A facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.
Indexed Variable Costs	The sum of a facility's allowable base and support costs per resident day indexed to October 1 of the year that is one year prior to the rate year being calculated.
Leave Day – Hospital	A day for which a facility may be reimbursed by Medicaid to hold a resident's bed for their return. (Medicaid policy pertaining to reimbursement is contained in the Coverages portion of this chapter.) Leave days reimbursed by other payer sources must be included in the facility census for cost reporting purposes.

Leave Day – Therapeutic	A day where a facility may be reimbursed by any payer source to hold a resident's bed for their return. Medicaid policy pertaining to reimbursement is contained in the Coverages portion of this chapter. The day is counted as a census day of care for resident occupancy on the nursing facility's cost report.
Management Company	An entity contracted by a licensed and Medicaid-enrolled nursing facility provider to manage one or more of the daily operations of the facility.
Medical Care Facility (MCF)	A county-operated nursing facility.
Minimum Data Set (MDS) Assessment	Clinical assessment tool required for all Medicaid-or-Medicare certified long-term care facilities. The federally required Omnibus Budget Reconciliation Act (OBRA) MDS assessments listed in A0310A of the MDS 3.0 Resident Assessment Instrument (RAI) Manual are the only assessments that may be used to determine rates for Class VII facilities.
Net Quality Assurance Supplement (Net QAS)	The QAS minus the non-Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax.
Net Quality Measure Initiative Amount (Net QMI Amount)	The Quality Measure Initiative payment amount minus the Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax.
New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility, an existing facility that has never before participated in the Medicaid program, a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. The consecutive fiscal years must cover a period of at least 24 months in total and may only cover dates in which the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day. A nursing facility that has made physical plant additions or renovations, including a total replacement or a facility that has been sold or resold is not considered a new facility.
New Provider in a Medicaid-Enrolled Facility	A person or business entity that has purchased or is purchasing a nursing facility that previously had Medicaid participation and whose new ownership individual(s) or business entity are not related through family or business ties to the owner's business entity of the previous owner. Under certain circumstances, a sale between family members may be approved by the SMA and the new owner may be considered a new provider.
Non-Medicare Nursing Facility Days	Nursing Facility days for which Medicare (Part A [Fee for Service] and Part C [Medicare Advantage, including MI Health Link days where Medicare is the primary payer]) is not the primary source of reimbursement.
Non-statistical Sampling	An audit sampling method that does not meet the definition of statistical sampling. Under an audit using solely non-statistical sampling methods, extrapolation methods may not be used to determine audit adjustments.
Nursing Facility or Nursing Home	A facility (or distinct part of a facility) that is licensed and certified by the State of Michigan or certified by CMS to provide nursing care and related medical services for residents who require such care above the level of room and board.

OBRA	The federal Omnibus Budget Reconciliation Act, initially passed in 1987 as Public Law 100-203, with amendments in 1988, 1989, 1990 and 1994. This law incorporated specific provisions for nursing facility reform, including revised requirements for the survey and certification process and for the enforcement process.
Occupancy	See Resident Days/Occupancy.
Occupancy Rate	The total number of resident days in a given period divided by the number of available bed days in the facility for the same period.
Owner/Administrator	A person who is employed and functions as the administrator, assistant administrator, business manager, or in any other administrative capacity in the nursing facility, and who is also part or full owner of the nursing facility operating entity, i.e., the provider and/or the nursing facility's real property. If a Director of Nursing is an owner and acts occasionally in an administrator capacity, the time acting in an administrative capacity is allocated to the owner/administrator salary.
Ownership/Corporate Interest	A person, partnership, or corporation that: ▪ Has ownership interest totaling 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has an indirect ownership interest equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has a combination of direct and indirect ownership interests equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility, if that interest equals at least 5% of the value of the property or assets of the facility/disclosing entity; or ▪ Is an officer or director of a nursing facility, i.e., in the disclosing entity, that is organized as a corporation; or ▪ Is a partner in a nursing facility, i.e., in the disclosing entity, which is organized as a partnership. Examples: ▪ If Ms. C owns 10% of a note secured by 60% of the nursing facility provider's assets, Ms. C's interest in the provider's assets equates to 6% and must be reported. Conversely, if Mr. S owns 40% of a note secured by 10% of the provider's assets, Mr. S's interest in the provider's assets equates to 4% and need not be reported. ▪ If Mr. F owns 10% of the stock in a corporation that owns 80% of the nursing facility, Mr. F's interest equates to an 8% indirect ownership interest and must be reported. Conversely, if Ms. N owns 80% of the stock of a corporation that owns 5% of the stock of the nursing facility, Ms. N's interest equates to 4% indirect ownership interest and need not be reported.
Patient	See Resident.

Patient Driven Payment Model (PDPM)	Classification system used to place nursing facility (NF) residents into different case-mix categories as determined by the Minimum Data Set (MDS) and used to set payment rates for Class VII facilities. PDPM consists of four case-mix categories and six rate components. The physical therapy (PT) and occupational therapy (OT) component, the speech-language pathology (SLP) component, the non-therapy ancillary (NTA) component, and the nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component.
Per Resident Day Cost	The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.
Plant Costs	Plant costs include depreciation, interest expense (incurred for either working capital or capital indebtedness, mortgage discount points), property taxes, amortization costs associated with loan financing costs (e.g., letters of credit), letter of credit application or commitment fees, amortization of legal fees pertaining to acquisition, recording fees or other fees relating to the capital asset acquisition, and specific lease expenses.
Preceding Owner	The person, partnership, or corporation that owns a nursing facility and is selling it through the CHOW process.
Property Owner	A person, partnership, corporation, organization, or entity, other than the nursing facility provider, having the property rights to the building in which a nursing facility operates or to the land on which a nursing facility sits.
Proprietary Provider	A provider or organization that is organized and operated with the expectation of earning profit for its owner[s], as distinguished from providers organized and operated on a nonprofit basis. Proprietary providers may be sole proprietorships, partnerships, or corporations.
Provider	A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program. Some conditions of provider participation continue after enrollment in Medicaid has ended, e.g., record retention.
Purchase Allowance	A deduction granted for damage, delay, shortage, imperfection, or other causes, excluding discount and return.
Purchase Discount	A reduction (off the original price for property, goods or services) granted for the settlement of debts (e.g., 5/10 days which means a 5% discount if paid within 10 days).
Purchase Price	The total price agreed upon between a buyer and a seller for property, goods or services.
Quality Assurance Assessment Factor (QAAF)	The percentage increase determined and implemented by Medicaid for a class of nursing facilities.
Quality Assurance Supplement (QAS)	The product of the QAAF for the class times the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit. Class III publicly-owned facilities basis is the lesser of the Class III VCC or the Class I VCL.
Quality Measure Initiative (QMI)	Quality Assurance Assessment Program funded payments to nursing facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website, along with a resident satisfaction survey factor.

Related Entity or Organization	An entity having a business relationship with a nursing facility provider that has 5% or greater beneficial interest or common ownership in or has control of the facility or the facility owner, whether such control has legal standing or is utilized. Also see Chain Organization and Ownership/Corporate Interest.
Related Party	An individual, group of individuals, or business entity that meets criteria similar to that defining a related entity or organization.
Resident	An individual who has been admitted to the provider's facility and has not been discharged.
Resident Days/Occupancy	Resident days or occupancy for nursing facility Medicaid cost reporting is the sum of the census days in a specified period of time. To calculate the resident days for a particular day, total the census days for that day. (Medicaid residents who are hospitalized are not counted in the census). Example: Residents occupying beds in facility = 100 Residents on therapeutic leave = 5 Hospitalized Medicaid residents = 3 Paid bed hold days = 1 Total resident days = 106
Restricted Revenue	Revenue that is designated or earmarked, by law, to finance some specific activity or group of related activities.
Routine Nursing Costs	Costs including, but not limited to, necessary medical, nursing, and mental health services, and all items of expense that nursing facility providers incur in the provision of routine nursing services. Costs must be included in the nursing facility provider's Medicaid cost reporting in accordance with established cost classifications.
Routine Nursing Services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, who enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well being in accordance with a written plan of care.
Settlement	The process of reconciling a nursing facility's interim rates based on filed cost report data to audited cost report data. A final settlement is computed after the cost report has been audited, a final rate based on audited data is issued, and all appeals have been adjudicated.
State Medicaid Agency (SMA)	The Michigan Department of Health and Human Services (MDHHS). The work unit within MDHHS with administrative responsibility for the Medical Assistance (Medicaid) Program is the Behavioral and Physical Health and Aging Services Administration (BPHASA).
State Survey Agency (SSA)	The Michigan Department of Licensing and Regulatory Affairs (LARA). The work unit within LARA with administrative responsibility for nursing facility survey and certification is the Bureau of Community and Health Systems (BCHS) and the Bureau of Survey and Certification (BSC).

Statistical Sampling	An audit sampling method that has the following characteristics: ▪ random selection of the sampled items; ▪ the use of probability theory to evaluate sample results; and ▪ the use of valid statistical procedures. Under an audit that solely or partially uses the statistical sampling method, extrapolation methods may be used to determine audit adjustments.
Successive Owner	The person, partnership, or corporation that is purchasing a nursing facility through the CHOW process.
Support Costs	Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, fringe benefits) for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs not specifically identified as base; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.
Support Costs Per Day	A facility's support costs divided by the total number of resident days for the same period.
Support Cost Component, Indexed	See Indexed Support Cost Component.
Support-to-Base Ratio	A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited base period, regardless of ownership.
Support-to-Base Ratio Limit for Bed Size Group	The support-to-base ratio limit for a bed-size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank-ordering facilities within the same bed-size group from the lowest to the highest support-to-base ratio, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the group are reached. The support-to-base ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.
Swing Beds	A program of short-term nursing care not exceeding 100 days, provided to patients in a hospital as defined in federal law and Michigan statute.
Therapeutic Leave Day	See Leave Day – Therapeutic.
Variable Costs	A facility's total allowable base and support costs for providing routine nursing services to residents, as determined in the Allowable Costs Section of this appendix. Also see definitions for Base Costs and Support Costs.
Variable Cost Component	The lesser of a facility's Variable Rate Base or the Class Variable Cost Limit, plus the Economic Inflation Update.
Variable Cost Limit	See Class Variable Cost Limit.

Variable Costs Per Day	A facility's variable costs (total base and support costs) divided by the total number of resident days for the same period.
Variable Costs, Indexed	See Indexed Variable Costs.
Variable Rate Base	The sum of a facility's indexed base cost component and indexed support cost component. For rate setting purposes, the figure used as the facility's Variable Rate Base is the lesser of the facility's calculated Variable Rate Base or the Class Variable Cost Limit.

SECTION 3 - OWNERSHIP CHANGES AND MEDICAID TERMINATION

3.1 PREREQUISITE

During a nursing facility CHOW, the successive owner must complete any Certificate of Need (CON) or provider screening and enrollment activities to complete the CHOW process. The CON requirement must be satisfied before Medicaid enrollment can occur. MDHHS administers the CON Program through the CON Evaluation Section. (Refer to the Directory Appendix for contact information.) The provider screening and enrollment requirements can be found in the General Information for Providers chapter of the MDHHS Medicaid Provider Manual.

On the CMS-established effective date of a nursing facility CHOW, the preceding owner's provider agreement shall automatically assign to the successive owner. The Medicaid assignment of the provider agreement binds the successive owner to all terms and conditions of the preceding operator's provider agreement including, but not limited to, liabilities such as Medicaid overpayments and debts, sanctions, and penalties related to the Medicaid program regardless of when they arose.

3.2 OWNERSHIP CHANGES

When an ownership change is anticipated, the proposed Seller(s) and the proposed Purchaser(s) must provide written notice to both the State Medicaid Agency (SMA) and the State Survey Agency (SSA) at least 90 calendar days prior to the anticipated ownership change. The written notice to the SMA must be sent to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) and to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) The written notice to the SSA must be sent to the nursing facility's team manager. Failure to provide written notice to either agency could result in payment and settlement delays.

Prior to the ownership change date, the new ownership must complete a New Provider Information Packet to provide RARSS with the necessary information for the rate setting and reimbursement process. Failure to provide this information prior to or immediately upon completion of the purchase will delay the rate setting and reimbursement processing for the new ownership. For New Facility/Owner Requirements, refer to the Cost Reporting Section of this appendix.

If a nursing facility changes ownership, the facility must register the NPI for the successive owner through the on-line CHAMPS Provider Enrollment (PE) subsystem. If the provider tax identification number (TIN) did not change, the NPI can be reported through the CHAMPS PE maintenance function. If the change involves a new TIN, the successive owner provider must complete a new enrollment application. The successive owner must not use the preceding owner's NPI for reporting and billing Medicaid services. In the event that the successive owner does not register the new provider NPI number in CHAMPS, the successive owner is still responsible for the liabilities associated with the provider agreement. Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information.

The Seller(s) and the Purchaser(s) will be notified by RARSS and advised of any requirements related to cost reporting and rate setting, including final settlement for the former owner. For information regarding reimbursement settlement, refer to the Cost Report Reimbursement Settlement Section of this appendix.

3.3 Nursing Facility Sale Between Family Members

The sale of a family owned nursing facility between family members is allowable and recognized as a transfer of ownership and a recognized sale transaction for Medicaid reimbursement within allowable cost and reimbursement limits if all of the following requirements are met. However, if it is subsequently determined control is not relinquished by the prior entity or interested parties, asset values will revert back to the values prior to the recognized sale and any additional reimbursement paid will be recovered.

- A purchase contract or agreement must be present. The transaction must terminate the seller's interest in the business. The seller must not have any recourse or ownership protection to retain or have a security interest in obtaining future ownership of that nursing facility in the event of the termination of the new ownership (purchaser) at a later date.
- Borrowing or financing for the sale transaction must be between the purchaser and a non–related third party (i.e., a financial institution). Financial loans from the family-related seller individual or entity to the family-related purchaser are not allowable for reimbursement. The finance instrument must not be a land contract from the seller.
- Total dollar amount of allowable borrowings cannot exceed the purchase price (allowable asset value). The Capital Asset Value (CAV) limit applicable to the nursing facility immediately prior to the sale, appropriately adjusted for nursing facility asset items that are excluded from the sale transaction, is the maximum reimbursable borrowing balance applicable to the asset transaction.
- The nursing facility property appraisal must be obtained. The facility appraisal value must support the purchase price negotiated between the sales parties. Refer to the Appraisal Guidelines Section of this appendix for additional information.
- The new ownership operation must be a different legal entity in which the family-related seller is not an officer or board member exercising control over the new operation. The nursing facility entity may remain as an ongoing business entity in a situation where the real estate sale does not involve the licensed nursing facility operator. This occurs where a related party lease exists between the nursing facility entity prior to the real estate transaction, and the real estate transaction of the leased nursing facility is between the family-related parties. The requirement that the family-related lessor/seller cannot exercise active interest or control in the management of the nursing facility after the sale must be met.

The following will be applied to a change in ownership as a result of a sale between family members:

- The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller party (or nursing facility entity owned by the family member) minus the dollar amount of depreciation expense allowed and reimbursed under the Medicaid Program. There is no increase in nursing facility asset values. MDHHS considers Medicaid reimbursement to the nursing facility for depreciation expense was zero dollars during the period that the seller provider was reimbursed by Medicaid for plant cost based upon capital asset value tenure reimbursement rate.
- The tenure factor for the nursing facility following the sale will revert to zero due to the capital asset transaction affecting a plant cost increase.
- The Medicaid program plant cost reimbursement limitations of the Deficit Reduction Act (DEFRA) of 1984 will not apply to the transaction as a result of the purchase limitation to the historical asset cost base of the seller.

- The seller may be subject to depreciation recapture dependent on the sale price of the assets and the depreciation reimbursement made to the seller during the period in which the seller was reimbursed a plant cost component under the depreciation cost method. The reimbursement period of depreciation recapture is limited to Medicaid services reimbursed during the period from October 1, 1984 through the date in which the nursing facility transferred to the tenure plant cost component reimbursement. The dollar amount of depreciation recapture may impact the asset acquisition allowable dollar amount for the purchaser.

3.4 Facility Asset Change of Ownership

In the event of a binding agreement and/or sale occurring on or after July 18, 1984, the Plant Cost Component for the nursing facility, attributable to the agreement and/or sale, is limited to the Medicaid Program policy provisions applying federal reimbursement limits of the DEFRA. Refer to the plant cost component rate determination provisions in the Rate Determination Section of this appendix for additional information.

At the time of the facility asset ownership change, the Provider must complete a Plant Cost Certification and submit a copy of the purchase and/or lease agreement, along with plant cost information, to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS). The information is necessary to establish the reimbursement rate for the Plant Cost Component due to the asset ownership change. For Plant Cost Certification requirements and timeframes for filing the data, refer to the Plant Cost Certification Section of this appendix.

For an explanation of the effect of the sale of assets on the Tenure Factor, refer to the Rate Determination Section of this appendix.

In the event of a sale after March 31, 1985, Medicaid will recapture from the selling provider any reimbursement received in the form of depreciation expense, through the date of either the sale and transfer of assets or, for a Class I facility, that provider's conversion to a "Return on Current Asset Value Component" reimbursement, whichever is earlier. This reimbursement provision does not apply to Class I nursing facility providers whose ownership began after March 31, 1985. For information regarding depreciation reimbursement adjustment, refer to the Cost Report Reimbursement Settlements Section of this appendix.

3.5 Termination of Medicaid Participation

A nursing facility that loses its Medicaid certification as a result of regulatory action, irrespective of whether that action requires facility closure, or a nursing facility that chooses to terminate its participation in the Medicaid program without closing must comply with notice and cost reporting requirements. Refer to the Cost Reporting Section in this appendix and to the Notification Process for Regulatory Actions, Nursing Facility Closure Protocol, or Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure subsections in the Certification, Survey & Enforcement Appendix of this chapter for relevant information.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

SECTION 4 - COST REPORTING

A nursing facility participating in the Medicaid program must submit a Medicaid cost report to MDHHS annually as a condition of participation. An electronic copy of the cost report, the cost report completion instructions, completion and submission checklists, and related information are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.1 EXCEPTIONS

4.1.A. EXCEPTION FOR HOSPICE PROVIDER OWNED NURSING FACILITY

A hospice provider that owns and operates a nursing facility is not required to file an annual cost report to Medicaid. The nursing facility industry aggregate cost data is used in place of individual facility cost data to establish a Medicaid reimbursement rate for this type of nursing facility. Rate determination procedures are addressed in the Rate Determination Section of this appendix.

4.1.B. EXCEPTION FOR SWING BEDS

Hospitals providing short term nursing services (swing beds) are not required to submit a Medicaid nursing facility cost report. Costs associated with swing beds are combined with those of the hospital and submitted on the hospital cost report. Refer to the Hospital Chapter of this manual for information regarding cost reporting requirements related to swing beds.

4.1.C. STATE VETERANS' HOMES

A State Veterans' Home is not required to submit a Medicaid NF cost report. The Medicare SNF cost report is used in place of the Medicaid cost report. The Medicare cost report is to be submitted electronically to the MDHHS Reimbursement and Rate Setting Section (RARSS) through the MDHHS File Transfer application. The Medicare Principles of Reimbursement apply for cost reporting purposes rather than the allowable cost principles described in the Allowable and Non-Allowable Costs section of this Appendix. The cost reporting requirements in the Less Than Complete Cost Report, Cost Report Due Date, New Facility/Owner Requirements, Changing a Cost Reporting Period, and Cost Report Delinquency subsections of this Appendix are still applicable.

4.2 NURSING FACILITY COST REPORT

An annual cost report is required for the cost reporting period which is based on the nursing facility's fiscal reporting year end. Each cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility. These records must be maintained in a manner consistent with the Medicare Principles of Reimbursement, except where modified by Medicaid policy. Records must also be kept in a manner consistent with previous cost reporting periods. The accrual method of accounting is mandated for all providers. For any cost situation that is not covered by the Medicare Principles of Reimbursement guidelines or Medicaid policy, Generally Accepted Accounting Principles (GAAP) should be applied.

Related organizations and costs to related organizations, as defined in federal policies and regulations, must be disclosed on the nursing facility cost report. Related organization costs claimed for Medicaid reimbursement through the nursing facility's rate determination process must be documented to RARSS on a completed home office cost report or on alternative cost reporting schedules as defined in the Home Office, Chain Organization, or Related Party Cost Reporting subsection of this appendix.

RARSS retains the filed nursing facility cost reports for a minimum of three years from the date of receipt. Nursing facilities are required to retain documentation supporting filed cost reports for a minimum of seven years from the end of the applicable cost reporting period, or beyond the seven year period if audit determinations have not been resolved.

4.3 Cost Report Requirements

The RARSS will send a notice electronically through the File Transfer application to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. The provider will have access to the specific information required to file an acceptable Medicaid Cost Report package in File Transfer. File Transfer has the applicable electronic cost report template, completion instructions, construction cost index for asset acquisitions, and other pertinent information in downloadable form.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- An electronic copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and physically signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's detailed general ledger and complete (no grouping or summary) trial balance of revenues and expenses. Both documents must be submitted as electronic Excel files.
- A completed cost report submission checklist.
- Copies of supporting workpapers for all Worksheet 1-A and Worksheet 1-B adjustments as electronic Word or Excel files (invoices may be submitted as PDF files).

The completed cost report package must be delivered electronically through File Transfer to RARSS as indicated in the notice.

4.4 Cost Report Acceptance

Each cost report submitted to RARSS is verified prior to its acceptance. The cost report package will only be accepted if all of the following conditions are met:

- The package is complete.
- The cost report calculations are mathematically accurate, reasonable and consistent.

- The completed electronic cost report (ECR) data uses the required software and specified format.
- MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file.
- An electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.
- The data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements.
- The submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues.
- The cost report preparation complies with Medicaid policy and cost reporting instructions.

Prior to acceptance of the submitted cost report, RARSS may adjust inaccurate data reported on the cost report if correct data is available to RARSS and the adjustment would not impact the computation of the per diem reimbursement rate. For example, RARSS may adjust the Title XIX Routine Nursing Days reported on the cost report if there is large discrepancy between the reported days and actual billed Medicaid days from the reporting period.

A cost report is considered not filed until it is accepted by RARSS. If the submitted cost report is determined to be unacceptable, RARSS will return the cost report to the nursing facility for correction and provide notice of the date the corrected cost report is due. The returned cost report will include information that indicates the reason(s) for the unacceptable report.

A corrected cost report – a revision of the most recently submitted cost report – may be submitted to RARSS for acceptance upon approval by RARSS. The provider should contact RARSS to obtain the acceptance status of that reporting period's most recent cost report ECR file prior to submission of a corrected cost report. A corrected cost report that is accepted by RARSS defaults as the original cost report.

MDHHS shall accept a non-delinquent cost report no more than 60 calendar days after the cost report is filed.

4.5 Less Than Complete Cost Report

With written approval from the RARSS, a nursing facility may submit a less than complete cost report.

4.5.A. No Medicaid Utilization

A nursing facility with no Medicaid utilization during a cost reporting period is required to submit a less than complete cost report.

4.5.B. Low Medicaid Utilization

A nursing facility with low Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. "Low utilization" is defined as an average of less than six Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must submit a written request to RARSS for approval to file a less than complete cost report for the specific cost reporting

period. The request must be signed by an authorized representative of the nursing facility, identify the reporting period the request applies to, include the facility's name and provider NPI number, and:

- Indicate the reason(s) for the request.
- Indicate Medicaid utilization and the approximate Medicaid dollar amount of payments received for the year.

The written request must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

After RARSS reviews the filed utilization and payment information, RARSS will send a written response to approve or deny the facility's request to submit a less than complete cost report. If approved, the facility will be required to furnish the following information using the required formats (ECR file worksheets):

- Information and Certification page.
- Statistical and Fiscal Data page.
- Ownership Information and Questionnaire.

In addition, the facility must prepare and submit the following information for the cost reporting period:

- Balance Sheet, and
- Prepared Financial Statements.

The nursing facility must submit the data within the same period required for complete cost reports. Medicaid reserves the right to require the facility to file a complete cost report.

4.6 Cost Report Due Date

The RARSS will notify the nursing facility of the cost report due date by letter mailed to the nursing facility or designated business office. An acceptable cost report must be received by RARSS within five months following the nursing facility's cost reporting period end date. Subsequent notice of the cost report due date is addressed in the Cost Report Delinquency subsection of this appendix.

A cost report is considered filed timely if the acceptable cost report is submitted to the RARSS on or before the last day of the fifth month following the cost report period end date. Late submission of an acceptable cost report may cause a delay in determination of the provider's annual reimbursement rate and the rate notice to the provider. Refer to the Rate Determination subsection of this appendix for additional information.

4.6.A. Corrected Cost Report Due Date

If a cost report is returned to the provider as unaccepted by the LTC Reimbursement and Rate Setting Section (RARSS), the provider is given five business days from the date of the RARSS cost report return letter to submit a corrected cost report via File Transfer. A

written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification and a cost report late file penalty may be applied. Refer to the Cost Report Delinquency subsection of this appendix for additional information.

4.6.B. Cost Report for Facility Closure or Change of Ownership

A nursing facility that has terminated its Medicaid program participation, either voluntarily or as the result of regulatory action, is required to submit a final cost report within five months following termination date.

The former owner of a nursing facility that has undergone a change of ownership is required to submit a final cost report within five months following the effective date of the ownership change.

4.7 New Facility/Owner Requirements

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year, cost reporting period, and other pertinent information regarding the nursing facility. In order for RARSS to establish the facility's Medicaid reimbursement rate, this notice must be submitted to MDHHS at least 30 calendar days prior to the begin date of Medicaid participation. Untimely submission of the data will result in delaying Medicaid payment to the nursing facility.

The new provider information packet is available by request to the RARSS. An electronic copy of the packet may also be accessed on the MDHHS website. (Refer to the Directory Appendix for contact and website information.)

The new provider information data must include the following items:

- Medicaid operations begin date.
- Fiscal year reporting period.
- Federal employer identification number.
- Facility business name.
- Corporate name (if different from business name).
- Facility address.
- Business mail address (if different from facility address).
- Affiliation to a home office chain or related nursing facility group, including corporate organization, address, fiscal reporting period, federal employer identification number and contact person information.
- Nursing facility Medicare Program status.

The new provider information data packet must be signed and submitted by an authorized representative of the nursing facility.

4.8 Changing a Cost Reporting Period

An annual cost report is required for the reporting period based on the nursing facility's fiscal reporting year. A nursing facility must file an annual cost report in accordance with the cost reporting period established with RARSS. However, under certain circumstances, RARSS may authorize a change in the nursing facility cost reporting period. The new cost reporting period must concur with the period of the nursing facility financial reporting year.

4.8.A. New Facility/New Ownership Initial Cost Report

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report and any related home office cost reports must cover a period of at least two months but may not exceed 13 months.

4.8.B. Written Request for Cost Reporting Period Change

A nursing facility owner interested in changing a cost reporting period must submit a written request to RARSS. The request for such a change must be filed at least two months prior to the first day of the new fiscal reporting period being requested. The request must include documentation supporting the change, such as a copy of an approval of Medicare Program reporting change or Internal Revenue Service reporting year change notice. If the reporting year change is not yet approved by these agencies, a copy of notice to Internal Revenue Service reporting or application for Medicare Program reporting change may be submitted. The request must also include a copy of the nursing facility director or governing board approval resolution or minutes adopting the fiscal reporting revision.

RARSS will notify the provider in writing of the approval or denial of the request and cost report period requirements resulting from the request.

4.8.C. Approval for Transition Period Cost Reporting

If the change is approved, the nursing facility will be required to file a cost report for the period between the end date of the original cost reporting period and the beginning date of the new cost reporting period. This cost report must cover a period not less than two months and not more than 13 months. Cost report periods that cover a period less than seven months may be used for Medicaid reimbursement for retrospective cost settlement determination for specific cost items, but are not used for prospective rate setting determinations affecting a subsequent rate setting year.

4.8.D. Extended Period Cost Report

A provider may submit a request for a cost reporting period of more than 12 months but not greater than 13 months if:

- the provider is terminating Medicaid Program participation; or
- the facility is closing.

Written request must be made to the RARSS and must outline the exceptional circumstances. The provider will be notified in writing of approval or denial.

The RARSS may approve such requests if the Medicaid program or the nursing facility is not significantly adversely affected. Examples include requests in which:

- the request is not made for purpose to gain access to higher ceiling rates or economic inflation adjustors;
- the cost report data will have limited use for reimbursement determinations, i.e., not used for annual rate setting;
- the report is not used for subsequent period rate determination; and
- it is used solely for retrospective settlement items.

4.9 Cost Report Delinquency

The nursing facility cost report is considered delinquent if:

- The cost report is not received by RARSS within five business days of the date on the Delinquency and Medicaid Payment Termination Notice.
- A corrected cost report has not been received by RARSS by the cost report due date or correction period due date and the cost report remains not filed with RARSS.

If the nursing facility cost report is delinquent, RARSS will share a delinquency and Medicaid payment termination notice with the nursing facility or the provider's designated business office through File Transfer. The notice will indicate the date (not less than ten business days from the notice date) on which Medicaid payment will be terminated unless a cost report is received by the RARSS. If the cost report is not received after ten calendar days, a notice will be sent that the Medicaid payment will be terminated, and the following penalty will be assessed.

Upon delinquency, the provider's interim payments will be reduced by 100 percent and the provider may be assessed a late-file penalty of ten percent of any claims for dates of service beginning on the 15th of the month after the cost report was due until a complete and acceptable cost report is received.

If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process. Medicaid will remove the payment termination entry pertaining to the cost report delinquency action allowing the release of all payments withheld for the cost report delinquency action. However, the ten percent late-file penalty will apply to these claims. Even when a complete and acceptable cost report is received, the late-file penalties will be applied through the gross adjustment process. No repayment schedules will be allowed for any penalty assessments. This penalty does not apply to Class VII facilities.

For providers with licensed-only beds and Medicare-only facilities, a penalty of $20 per bed, per day, will be assessed beginning on the 15th of the month after the census data is due until the data is received. This penalty may be assessed even if MDHHS has provided a written notice of termination to a facility.

For providers who still do not submit a complete and acceptable cost report or the appropriate census data 60 days after delinquency, the total number of licensed beds, multiplied by 365 days, will be used as the number of taxable days for the calculation of the Quality Assurance Assessment Program. This will apply to both Medicaid and non-Medicaid providers.

4.10 Amended Cost Report

An amended cost report to adjust a previously accepted cost report may be permitted or required by Medicaid.

An amended cost report is accepted by Medicaid to:

- Correct material errors detected subsequent to the filing of the original cost report.
- Comply with health insurance policies or regulations.
- Reflect the settlement of a contested liability.

Before completing and submitting an amended cost report, the nursing facility should contact the RARSS by verbal or written communication to determine the appropriate mode for making the necessary amendment(s). Amended cost report data will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning in the month following the receipt of the provider's notice to RARSS of the need to amend the cost report.

The provider must include a disclosure letter with the amended cost report identifying the reason for the amended report and citing the cost report Worksheet(s) and the data input cell(s) within the Worksheet(s) that have been revised.

Providers cannot amend an audited cost report or amend a filed cost report after the reimbursement rate period has ended (i.e., a 2017 year-end cost report cannot be amended after it is audited or after September 30, 2019, whichever comes first). Amended cost reports will not be accepted by RARSS after the completion of an audit except in cases where the filed and audited cost report continues to be the basis for the nursing facility's current reimbursement rate. An amended cost report must properly reflect any audit adjustments made to the original cost report. Amended data will be used, as appropriate, to compute future rates but will not be used to retroactively change a previously paid prospective rate. Use of amended cost report data for retroactive application to prior services will only be made in cases related to fraud or failure to disclose required information in the cost reporting. Situations where retroactive changes are permissible are described in the Cost Report Reimbursement Settlements Section of this appendix.

4.11 Home Office, Chain Organization, or Related Party Cost Reporting

Nursing facilities that have costs applicable to services, facilities, and supplies furnished to the provider by organizations or entities related to the nursing facility by common ownership or control may include the costs in the nursing facility cost report. These costs may arise from arrangements involving a home office of a chain organization or services provided to the nursing facility or purchased by the nursing facility from related party businesses.

For facilities that are operated as part of a chain organization, home office costs claimed on the individual nursing facility's cost report must be reported using the Medicaid Nursing Facility Home Office Cost Statement (MSA-1578).

For nursing facilities reporting costs of services provided by a related party organization, the MSA-1578 must be used for reporting costs. An electronic copy of MSA-1578 will be available to providers in File Transfer. Alternative cost reporting worksheets or accounting schedules may be substituted for the Home Office Cost Statement if RARSS agrees that the alternative format provides supporting documentation to adequately identify expenses and the allocation of costs to the nursing facility. RARSS will approve the format as submitted, require additional data or revisions to the reporting format, or disapprove the alternative reporting.

When the fiscal year for the home office or related organization coincides with the nursing facility's fiscal year, the due date for the home office or related party organization cost report must coincide with the nursing facility's annual cost report due date. In cases where the fiscal years do not coincide, the nursing facility must submit the cost report of the home office or related party organization for the most recently completed fiscal year of that entity. If the report was previously submitted to RARSS, it must be resubmitted by the same due date as the nursing facility's cost report. Exception: Participation in the cost allocation option (as outlined in the Related or Chain Organization Cost Allocation subsection of this chapter) supersedes this requirement. (Refer to the Related or Chain Organization Cost Allocation subsection in this appendix for additional information.)

4.11.A. Home Office Costs - Chain Organization

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization.

For Medicaid policy regarding allowable costs, refer to the Cost Classification and Cost Finding Section of this appendix.

4.11.B. Related Party Business Transactions

The operating costs of a related ownership organization are allocated to the individual nursing facility as a purchased service. This cost must be identified within the appropriate cost center in the Medicaid cost report. Identification of the type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility.

The related party organization cost reporting is required for the specific related party organization business entity in the following cases:

- If the dollar amount of routine nursing care costs to the individual nursing facility exceeds $25,000 in aggregate, regardless of the number or type of services provided.
- If the sum (total dollar amount) of routine nursing care costs to multiple nursing facilities exceeds $125,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served.

These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services. The dollar thresholds only apply to costs allocated to a Medicaid routine care unit, either directly or through the stepdown process (i.e., if

$25,000 in costs are allocated to a nursing facility from a related party, but none of the costs are allocated to the Medicaid routine care unit, then no home office cost report is required). Beginning October 1, 2018 and biennially thereafter, these amounts are updated based on the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Market Basket. Amounts are posted on the Long-Term Care Reimbursement and Rate Setting Section (RARSS) website. (Refer to the Directory Appendix for website information.)

Facility lease arrangements between related parties must be separately reported in the cost report as described in the Allowable and Non-Allowable Cost Section of this appendix.

Related party expenses must remain on the individual nursing facility cost report for the proper allocation of overhead costs regardless of whether they are ancillary or routine. This provision applies even if a home office cost report is not required.

4.11.B.1. Exception Process

An exception to the related party home office cost reporting requirements may be granted if all or part of the expenses are directly allocated to the nursing facility or facilities. If only part of the expenses are directly allocated, the sum of all other expenses allocated to a facility or facilities must be less than the dollar thresholds established in policy. Exceptions must be approved by RARSS prior to or on the due date of the home office cost report. Examples of expenses that would qualify for an exception include, but are not limited to, health insurance benefits, administrator and other staff salaries, retirement benefits, payroll taxes, other fringe benefits, contracted health services, medical supplies, office supplies, utilities, legal fees, etc.

4.12 Cost Report Filed Under Protest

As part of the cost settlement and cost report audit process, a nursing facility provider may dispute a Medicaid regulatory or policy interpretation. (Refer to the Appeal Process Section of this appendix for additional information.) If the provider has a dispute regarding the annual cost report, the nursing facility must submit a separate cost report, referred to as a "protest cost report" to establish their reporting of the dispute issue. In order to preserve the nursing facility cost report claim, this separate cost report must be identified as under protest for the disputed issues that remain under appeal or are subject to an appeal. The protest cost report filing must include an accompanying letter, signed by the nursing facility authorized representative, listing the disputed issue(s) and respective dollar amount(s) for the basis of the protest cost report filing. Protest cost reporting issues will be addressed in the cost report audit process dependent upon resolution of the disputed issues. The cost report filed under protest will not be used for rate determination, but will provide information for audit consideration relative to disputed issues. The auditor will address necessary audit adjustments to the accepted cost report to reflect the appeal resolution.

Protest cost report filing is not for general disagreement with promulgated Medicaid policy. The RARSS will not accept protest cost reports filings that include items considered as disagreement or dissatisfaction with promulgated policy.

SECTION 5 - PLANT COST CERTIFICATION

Medicaid reimburses nursing facilities for costs associated with capital asset ownership. The costs are referred to as plant costs and are reimbursed as the Plant Cost Component of the per diem reimbursement rate. The Plant Cost Component is based on the cost report data submitted by the nursing facility for the previous calendar year. The Plant Cost Component includes costs associated with capital asset acquisition, depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (letters of credit, asset acquisition legal fees) and specific lease expenses. The Plant Cost Component of the reimbursement rate determined for a nursing facility remains consistent throughout the State's fiscal year period (October through September), unless the facility qualifies for an interim reimbursement rate.

Example: Plant cost data from cost report year-end December 31, 2017 is the basis for the Plant Cost Component for the October 2018 through September 2019 rate period. Refer to the Cost Classification and Cost Finding, and the Rate Determination sections of this appendix for additional information.

The process used to determine if a facility qualifies for an interim reimbursement rate is called Plant Cost Certification. Special rate setting provisions qualify facilities to use current year costs associated with capital ownership instead of the prior year's cost report data to determine the Plant Cost Component of the reimbursement rate. Rate setting provisions are available for facilities incurring exceptional changes in the facility's plant costs during the current year. Qualifying situations such as new construction or renovation, new asset acquisition, new ownership, or changes in the nursing facility's bed size or the type of resident services are considered to determine eligibility for Plant Cost Certification.

5.1 PLANT COST CERTIFICATION ELIGIBILITY CRITERIA

A facility may plant cost certify when there is no plant cost data available or when the plant cost data inadequately reflects the current rate period plant costs. Plant Cost Certification is available in the following situations:

- The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $5,000 or more per licensed bed for a Class I or Class V facility or $3,000 or more per licensed bed for a Class III facility in capital expenditures in a single cost reporting period. Medicaid will update the capital expenditure per licensed bed amounts effective October 1, 2020 and biennially thereafter based on a construction cost index for steel frame buildings and rounded to the nearest $500 (i.e., $5,150 would round to $5,000, $5,250 would round to $5,500, etc.).
- There is an approved CON ownership change for an existing facility, or the nursing facility assets have changed ownership in a manner that requires CON review.
- The SSA has changed the class level of the facility, change in Medicaid certified beds, or the type of nursing or resident care services provided in the nursing facility.
- The nursing facility has an approved non-available bed plan in the cost report period.
- The nursing facility is in the first full cost report year following the termination of an approved non-available bed plan.

5.2 Plant Cost Certification Submission

The provider must complete the Plant Cost Certification process and qualify in order to receive an interim reimbursement rate. The RARSS must receive a compilation of the nursing facility's expected allowable plant costs and a statement signed by the nursing facility's authorized representative attesting to the data's accuracy and adherence to the Plant Cost Certification policy. The provider must use the MDHHS required format for document preparation. A provider having a nursing facility license and leasing the facility must report facility costs of the lessor in accordance with Medicaid's reimbursement policy. Refer to the Allowable Cost and Non-Allowable Cost, and Cost Classification and Cost Finding sections in this appendix for additional information.

A provider requesting an interim reimbursement rate must provide the information in the Medicaid Long Term Care Plant Cost Certification format and submit copies of supporting documentation. A copy of the format is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The Plant Cost Certification packet of accepted sample formats is available by request to RARSS. An electronic copy of the packet can also be accessed on the MDHHS website.

Supporting documentation must include the following items for a transfer of ownership of a license, acquisition, or lease that requires CON approval:

- Purchase Agreement
- Mortgage and Loan Agreements
- At least 36 months of Interest Amortization Schedules for Financing prepared by the lender
- Property Tax Statements
- Capital Asset Cost Appraisal
- Purchase Closing Statement or Recording

Supporting documentation must include the following items, where applicable, for a renovation, addition, or new construction:

- Licensed Bed Notice issued by the State Survey Agency (SSA)
- Mortgage and Loan Agreements, if applicable
- At least 36 months of Interest Amortization Schedules for Financing prepared by the lender
- Property Tax Statements
- Construction Contract Statement or Summary

RARSS must receive the provider's completed Plant Cost Certification prior to the cost reporting period filing deadline, and providers must meet the qualifications to receive an interim reimbursement rate. The completed information and supporting documentation may be sent to RARSS by mail, delivery, or File Transfer. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix for contact information.)

If RARSS determines that the plant certification eligibility criteria are met, the submitted cost data will be desk reviewed, adjusted if necessary, and used to calculate the nursing facility's Plant Cost Component. If the fiscal year cost report filing and subsequent cost report audit determine the data used to calculate

the reimbursement for the Plant Cost Component resulted in an overpayment or underpayment to the provider, the Medicaid recovery or additional reimbursement due the provider is included in the cost report reimbursement settlement. (Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.)

5.2.A. Plant Cost Certification Requirement for Reimbursement – Building and Equipment Changes

A new or existing provider or business entity operating a nursing facility that is incurring a change involving the nursing facility's building and equipment must complete a Plant Cost Certification. A provider that obtains ownership of the nursing facility building and equipment or enters a lease agreement for the facility must submit a completed Plant Cost Certification. In the instance that a lease change is the result of a facility ownership change where the provider has a different landlord, a plant cost certification is required if any terms of the lease agreement changes, such as lease amount, duration, etc.

The Plant Cost Component of the reimbursement rate will be zero until the Plant Cost Certification is received by the RARSS. In order to be eligible for retroactive reimbursement, the provider must submit a completed Plant Cost Certification on or before the date of the initial filing of cost report for the year in which the ownership change or asset transaction occurred. The effective date of the Plant Cost Certification will be the month that new ownership becomes the licensed entity or the asset transaction. Plant Cost Certification requests received by RARSS subsequent to the cost report filing will not be eligible for retroactive reimbursement, and future plant cost reimbursement rates will be effective as outlined under the effective period policy.

5.2.B. Plant Cost Certification Submission Waiver

If the provider qualifies for Plant Cost Certification under the approved non-available bed plan or because it is the first cost report year after the non-available bed plan termination, the data submission requirement is waived. The provider has the option to file during the rate year or to defer the plant cost rate revision until the cost report reimbursement settlement. Settlement adjustments for plant costs for the cost reporting period will automatically apply to non-available bed plan periods. If a Plant Cost Certification is not filed, the nursing facility's interim Plant Cost Component will continue to be based on the previous year's cost report, and the cost report reimbursement settlement will be adjusted to the allowable plant cost level for the cost report period. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

5.3 Plant Cost Certification Effective Period

The effective period of the plant cost certification will be determined by the RARSS. A completed Medicaid Long Term Care Plant Cost Certification request in required format, with documentation, received by the RARSS prior to the 16th of the month is effective and included in the reimbursement rate as of the first day of the following month (e.g., a request received between September 16 and October 16 will be reflected for days of care beginning November 1).

The effective date of the plant cost certification cannot be prior to the month in which the facility experienced the change of ownership or the qualifying asset change. The rate is not revised for partial months. For interim rate setting, the revised reimbursement rate due to the Plant Cost Certification will not be applied to prior service dates except in instances where a provider meets certification eligibility under the nursing facility ownership change or lease provisions. If a plant cost certification is filed prior to the provider's cost report year end, an interim reimbursement rate is effective on a prospective basis for service dates after filing date. Retroactive reimbursement due to the plant cost change for that cost report year services will be addressed in the initial and final settlement determination of the cost report. Refer to the Cost Report Reimbursement Section of this appendix for additional information.

If a Plant Cost Certification is filed after the provider's cost report year end filing deadline but prior to the rate year beginning immediately after the filing deadline, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the period established by the Plant Cost Certification request receipt date. Plant Cost Certifications filed on or after the rate year beginning after the applicable cost report filing deadline will not be accepted (i.e., if a provider has a December 31, 2018 cost report year end and made a qualifying capital change in 2018, then the provider would need to submit a Plant Cost Certification prior to October 1, 2019 for it to be accepted).

The Plant Cost Certification interim reimbursement ends when the nursing facility's prospective Plant Cost Component is based on the first complete cost report year that reflects the plant costs which qualified the nursing facility for Plant Cost Certification.

Example: A nursing facility with a cost report period of January 1, 2019 through December 31, 2019 completes an eligible renovation project in June 2019, and submits a Plant Cost Certification before June 16, 2019 to be effective July 1, 2019. (Note: Rate Year refers to a period coinciding with the state fiscal year rate period. The periods listed below the Rate Year identify the period during which the rate will be paid and the cost report year on which the rate is based.)

Nursing Facility Initial Period Interim Rates for Plant Cost Reimbursement

Rate Year: October 2018 – September 2019	October 2018 – June 2019: Plant cost for the cost year end December 2017	July 2019 – September 2019: Plant cost based on plant cost certification reflecting expected cost for the cost report year end December 2019

Nursing Facility Final Rates for Plant Cost Reimbursement

Rate Year: October 2018 – September 2019	October 2018 – December 2018: Plant cost for the cost report year end December 2017	January 2019 – September 2019: Plant cost for the cost report year end December 2019
Rate Year: October 2019 – September 2020	October 2019 – December 2019: Plant cost for the cost report year end December 2019	January 2020 – September 2020: Plant cost for the cost report year end December 2020

Rate Year: October 2020 – September 2021	October 2020 – December 2020: Plant cost for cost report year end December 2020	January 2021 – September 2021: Plant cost for the cost report year end December 2021
Rate Year: October 2021 – September 2022	October 2021 – September 2022: Plant cost for cost report year end December 2020	

5.4 Plant Cost Certification Updates and Revisions

The nursing facility's initial Plant Cost Certification will continue to be used for the interim Plant Cost Component unless the nursing facility submits a revision to the Plant Cost Certification.

Following the initial submission of the Plant Cost Certification, the nursing facility is responsible to submit an updated or revised Plant Cost Certification to assure the interim Plant Cost Component reimbursement is representative of the current rate period plant costs.

The nursing facility provider may revise its submitted Plant Cost Certification at the beginning of subsequent fiscal year rate periods or the beginning of a calendar quarter, but not more than two times per year. The effective timeframes for payment based on the updated information are the same as noted above.

The overpayment penalty provisions, if applicable, remain in effect regardless of payment based on initial submission or revised data.

5.5 Plant Cost Certification Overpayment Penalty

At the time of the MDHHS audit of the provider's fiscal year cost report, if the interim reimbursement payments resulting from Plant Cost Certification exceed cost report settlement plant cost reimbursement, all excess funds paid as a result of the Plant Cost Certification request will be recovered by Medicaid. The provider will be assessed a penalty for overpayments resulting from Plant Cost Certification. The penalty will be 10 percent of the aggregate dollar amount difference between the interim reimbursement payments resulting from the Plant Cost Certification and the cost report settlement plant cost reimbursement. The penalty will be waived if the aggregate dollar amount difference is equal to or less than 10 percent of the provider's aggregate Plant Cost Component reimbursement amount for the cost settlement period. Overpayment recovery and penalty determination are included in the Cost Report Reimbursement Settlements Section.

SECTION 6 – AUDIT

The goal of the cost report audit is to provide the MDHHS assurances that the cost report information is accurate for the determination of Medicaid reimbursement rates, and includes the following objectives:

- To review, analyze, and test the nursing facility's Statement of Reimbursable Cost and underlying financial records to confirm that only reasonable and allowable costs have been included.
- To confirm that the methods used to calculate the required statistical information are adequate and that the statistical data is recorded accurately.
- To confirm that the cost finding and cost apportionment have been accurately and fairly computed.
- To confirm the accuracy of the costs allocated to Medicaid by independently applying the method approved for the provider's use in computing reimbursable cost.
- To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement policies and regulations.
- To review, analyze and test the nursing facility's revenue and billings to determine the propriety of billing practices and identify potential errors and financial risk to Medicaid.
- To identify the underlying causes of significant errors or problems noted during the audit and to suggest improvements.
- To follow up on significant problem areas identified in previous audits.
- To confirm consistent and uniform application of federal and state laws, rules, and regulations for reimbursable costs.

The audit process described in this section is not applicable to State Veterans' Homes.

6.1 AUDIT PROCESS

The annual audit process may include a desk audit/review, a computer check, and/or an onsite audit. This process may be performed by MDHHS audit staff or by a qualified designee.

An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.

A Preliminary Summary of Audit Adjustments Notice is issued to the facility upon completion of the audit.

6.1.A. REQUIRED INFORMATION [CHANGE MADE 4/1/2025]

Each provider must allow access or arrange for access by MDHHS staff, or their designees, to required financial records and statistical data including:

- Records required by the Medicare Principles of Reimbursement
- Complete financial records of related organizations

- Complete records of lessors necessary to determine underlying costs of leasing facilities and items of equipment

These records include, but are not limited to, the following:

- Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e., hospital, therapeutic)
- Resident medical records, with details of medical services received by each resident
- Resident service charge schedules
- Resident trust fund account records, with evidence of quarterly reporting to each resident
- Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report, including appropriate approved time study information where applicable **(text added 4/1/2025)**
- Supporting documentation for Nurse Aide Training and Competency Evaluation Program activity and cost data
- Documentation to support the cost and activity level for special Medicaid reimbursement provisions beyond the scope of services included in routine nursing care
- Total and Medicaid ancillary charge summaries and logs
- Medicare Cost Report, if applicable
- Medicare and other health insurance billing and payment records for each resident
- Books of original entry, including standard/special journals, payroll journals, disbursement journals, etc.
- Employee records, including detailed payroll records, personnel files, employee wage scales, shift schedules, union contracts, agreements, fringe benefits (e.g., deferred compensation, pension plans, insurance, personal use of assets, special allowances), individual accounts of leave days, job descriptions, and payroll tax returns.
- Facility policy and procedure manuals and related materials
- Plans for internal control
- Minutes of meetings of the governing body
- General and subsidiary ledgers, including stock ledgers, cash receipts, etc.
- Purchase requisitions and orders
- Vouchers and invoices in detail to support services and goods purchased
- Records related to management fees, executive services or personal services contracts, and contracts for services under arrangement
- Charts of accounts
- Checking account registers, canceled checks, and bank statements
- Vehicle mileage and use logs
- Fixed asset records

- Capital expenditure records and depreciation lapse schedules
- Copies of long-term debt obligations, mortgages, notes payable/receivable, amortization schedules, year-end statements, and loan histories
- Tax returns, or federal informational returns for tax-exempt facilities
- Provider organization ownership disclosure records, e.g., Articles of Incorporation, Partnership Agreement, and other similar documentation
- Records regarding chain organizations, including corporate home office costs
- Work papers and records regarding the preparation of cost reports
- Audit reports of financial statements
- Work papers of internal and external accountants used in the preparation of the cost report(s)
- Records regarding working capital. Analysis of source and use of funds, which includes working capital loan principle payments
- Leases and all related records
- Accounts receivable Aging Schedule
- Accounts payable Aging Schedule

6.1.B. Audit Timeline

MDHHS shall ensure that an audit of a cost report is completed no later than 21 months after the final acceptance of a cost report, and that the 21-month period does not include any time associated with any appeal or a charge of fraud filed against the provider. A cost report not audited within the 21 months will be accepted as filed and move to settlement.

6.1.C. On-Site Audit

MDHHS shall complete an on-site audit on an as-needed basis. The on-site audit shall not last more than 30 calendar days per cost report year for an individual nursing facility, and not more than 30 calendar days per cost report year per nursing facility for two or more commonly owned or controlled facilities up to a maximum of 180 calendar days per cost report year (i.e., the on-site audit could last 60 days per cost report year for two facilities, 90 days for three facilities, etc. up to a maximum of 180 days for six or more facilities), unless MDHHS and the nursing facility agree in writing to extend the timeline. An on-site audit will occur where the nursing facility's records are located, regardless of whether those records are located on the nursing facility's premises or elsewhere. A limited-scope audit shall be performed for cost reports in which an on-site audit is not performed.

6.1.D. Audit Sampling

MDHHS shall use statistical sampling, non-statistical sampling, or a combination of sampling methods for selecting items to audit. If a combination of sampling methods is used, then the items that could be selected under the statistical sample cannot be

included in the non-statistical sample and vice versa (i.e., if 29 items are selected through a statistical sample out of a possible 500 items, then the other 471 items cannot be included in a non-statistical sample).

6.1.E. Scheduling an Audit

MDHHS will submit an Intent to Audit – Scheduling Notice at least 30 calendar days prior to the intended audit start date. The audit start date may take place no more than 10 business days after the intended audit start date or on a date prior to the intended audit start date. The provider must provide a response to the notice within five business days, otherwise the audit will begin on the intended audit start date. If the intended audit start date does not work for the provider, then they must notify MDHHS within five business days of the notice and provide alternative dates for the audit. If a mutually agreed upon audit start date cannot be selected, then the audit will commence on the intended audit start date.

6.1.F. Availability of Information

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by MDHHS Bureau of Audit staff or their designees. Documentation must be provided to support the actual expenditure of costs; non-actuarial estimates are not allowable supporting documentation.

Prior to the audit start date, MDHHS staff will submit an Audit Engagement Notice to the provider via File Transfer. This notice will include a list of the required documentation and the consequences for unavailable documentation. The documentation required by the Audit Engagement Notice must be available to MDHHS within 15 business days. If none of the documentation requested in the notice is available within 15 business days, then MDHHS will move to schedule an Exit Meeting. If some of the documentation is available, then the provider will have two or five business days to submit the unavailable documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If documentation is not released within the timeframes described in this paragraph, then the costs in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

While reviewing available documentation, MDHHS may determine that additional documentation is necessary to support an expense. MDHHS will submit a written request to the provider, and the provider will have two or five business days to submit the additional documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If the documentation is not released within the timeframes described in this paragraph, then the costs associated with the item in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

MDHHS will move to schedule an Exit Meeting or audit other expenses after the timeframes described in this subsection have passed, even if requested documentation is

not made available. (Refer to the Appeal Process Section of this appendix for additional information.)

6.1.G. Extrapolation

MDHHS may use extrapolation methods to determine audit adjustments for expenses included in the sampling universe (i.e., all items that have a chance to be sampled in a random sampling process) in a statistical sample. The provider will be notified if extrapolation methods were used in the Exit Meeting Summary of Audit Adjustments Notice, the Preliminary Summary of Audit Adjustments Notice, and the Final Summary of Audit Adjustments Notice. The notice will include the sampling selection methodology, the sample size, the disallowed expenses, and the extrapolation formulas and calculations. The Preliminary Summary of Audit Adjustments Notice will also include the provider's appeal rights, which include the ability to appeal the extrapolation methods used to determine the audit adjustment.

6.1.H. Exit Meeting

An Exit Meeting is a meeting offered to the provider to be held within five business days after the completion of the audit work to communicate the audit results to the provider and to obtain the provider's comments on the proposed findings of the audit prior to the issuance of the Preliminary Summary of Audit Adjustments Notice. The offer to schedule an Exit Meeting will be sent to the provider in the Exit Meeting Summary of Audit Adjustments Notice. To schedule an Exit Meeting, a provider must specify dates and times for the meeting to take place that are within five business days of the written offer to schedule a meeting. An Exit Meeting may be scheduled prior to the issuance of the Exit Meeting Summary of Audit Adjustment Notice, but if the scheduled Exit Meeting does not occur within five business days of the issuance of the Exit Meeting Summary of Audit Adjustments Notice, then the meeting date must change to occur within five business days of the notice. An Exit Meeting may be held in person, via telephone, or via electronic correspondence (i.e., email, video chat, etc.). If a provider does not attend a scheduled Exit Meeting, then the provider forfeits their right to an Exit Meeting. The provider may designate an authorized representative to attend the Exit Meeting (e.g., their cost report preparer, etc.).

In addition to the offer to schedule an Exit Meeting, the Exit Meeting Summary of Audit Adjustments Notice will contain a summary of MDHHS' proposed audit adjustments. The provider may submit additional information related to a proposed audit adjustment at the Exit Meeting and for up to two business days after the Exit Meeting (or within five business days of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held). MDHHS will not consider any additional information related to a proposed audit adjustment after two business days have passed from the date of the Exit Meeting (or five business days from the issuance of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held).

6.1.I. Completed Audit

A completed audit is represented by the issuance of the Preliminary Summary of Audit Adjustments Notice. The Preliminary Summary of Audit Adjustments Notice will be issued after the Exit Meeting is held or waived.

6.1.J. Retroactive Rate Changes [Change Made 4/1/2025]

A retroactive change in a nursing facility's rate and reimbursement may be made after completion of an audit in the following situations:

- For those providers that are retrospectively settled.
- For those providers that had an interim rate set prior to completion of the cost report audit.
- **(text deleted per bulletin MMP 24-55)**
- For audit adjustments required as a result of a hearing decision.

Refer to the Reimbursement Rate Determination section of this appendix for detailed information regarding retroactive effective periods for rate determination and reimbursement actions.

6.1.K. Reopening Audit Determinations

MDHHS may elect to reopen an audit determination following completion and closing of the audit of a nursing facility cost report. MDHHS will provide notice to the nursing facility of the audit reopening and the issues for which the audit is under review. Results of the audit reopening will be submitted to the provider, who will be given the opportunity to review the findings and appeal in accordance with Medicaid policy. If it is determined that the audited cost report contains incorrect data, MDHHS will use corrected data to compute future rates. The audit revisions will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning the month following notice to the provider that the subject audit is being reopened.

The results of audit reopening actions will only be effective for retroactive reimbursement revision in cases of fraud or when the provider's failure to disclose required information was pertinent to the determination of allowable cost.

MDHHS will not reopen an audit determination for any reason other than fraud beyond the 21-month period described in the Audit Timeline subsection of this appendix.

6.1.L. Record Retention

Each nursing facility's accounting and related records must be kept for a period of not less than seven years. This obligation does not end if a provider closes or sells a facility. All records, source documents, contractual agreements, and corporate minutes must be available onsite, or at a readily accessible location, for verification and inspection by MDHHS staff or their designees. When accounting personnel, books and records are

located out of state, the provider is required to pay auditor travel expenses if MDHHS staff or their designees deem it necessary to access documentation during the course of an audit.

6.2 Financial Fraud and Abuse

Federal Medicaid law and regulations require the Medicaid program to establish and maintain methods and criteria for the identification, investigation, and referral of potential fraud and abuse. In accordance with federal and state requirements, MDHHS will authorize the suspension of Medicaid payments (in whole or in part) to a nursing facility provider on receipt of reliable evidence that the provider committed fraud or willful misrepresentation while enrolled as a Medicaid provider. The provider will receive written notice of such suspension and may request an administrative review. (Refer to the Appeal Process Section of this appendix for additional information.)

A MDHHS auditor or designee who observes potential fraud or financial abuse will prepare a separate report of observations. Observations of potential fraud or abuse include, but are not limited to, the following:

- Recording of personal expenses
- Overutilization of services to inflate charges
- Unauthorized use of resident trust funds
- Payroll entries of personnel who provide no services
- Concealment of business activities
- Falsifying records
- Charging Medicaid for costs not incurred
- Duplicate billing
- Billing beneficiaries inappropriately for Medicaid services
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Knowingly failing to disclose required information in the Medicaid cost report

Reports of observations will be reviewed by MDHHS staff and appropriate actions taken. This may include forwarding a copy of the report and supporting documentation to the state Attorney General's Health Care Fraud Division.

SECTION 7 - COST REPORT REIMBURSEMENT SETTLEMENTS

The nursing facility reimbursement rate is determined in accordance with the policy provisions outlined in the Rate Determination Section of this appendix. The reimbursement rate may include routine nursing care services and various rate add-on amounts depending on the Medicaid reimbursement policy effective at the time. The facility rate is a per diem amount. Rate determination may be based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activity, or interim reimbursement provisions in accordance with Medicaid policies. The reimbursement rate is determined at the beginning of the rate year and the nursing facility is provided notice of the rate determination prior to implementation of the rate. The reimbursement rate may be revised any time during the rate year in accordance with rate determination policies. Rate revisions can result from the following actions as detailed in the Rate Determination Section:

- More recent Fiscal Year filed cost report
- Audited cost report
- Plant Cost Certification
- Nurse Aide Training and Competency Evaluation Program
- Special Dietary Cost Allowance
- Special Reimbursement policy actions

Reimbursement for ancillary services provided to Medicaid-eligible residents will be made in accordance with policies identified in the Coverage portion of this chapter and in the Billing & Reimbursement for Institutional Providers Chapter.

7.1 INTERIM REIMBURSEMENT AND RATE REVISIONS

The Rate Determination Section in this appendix outlines the process for determining the nursing facility's annual reimbursement rate. If RARSS determines that a reimbursement rate must be revised, the rate change may affect payment for future and/or previous dates of service. RARSS will notify the provider of the rate change and the rate's applicable period.

If a rate revision applies to future dates of service, RARSS will send written notice to the provider's designated address specifying the revised rate and the applicable period for the rate.

If a rate revision must be applied to previous dates of service in the current cost report year, RARSS will notify the provider of the applicable period and the reimbursement rate. If the rate revision applies to previous dates of service in the current cost report year, RARSS will make the determination of an underpayment or overpayment amount, and RARSS will notify the provider of the process for implementing the payment adjustment(s).

If the rate revision applies to a prior cost report year's dates of service, the payment adjustment process is addressed in the Initial Settlement Section of this appendix.

7.2 Initial Settlement

The SMA may determine that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. The retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After the filing and acceptance of the cost report, the RARSS will determine if an Initial Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Initial Settlement uses the most recent accepted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. (Refer to the Rate Determination Section of this appendix for additional information.)

The RARSS will consider provider requests for Initial Settlements on an exception basis in the following situations:

- The provider anticipates a significant amount due them by Medicaid and requests an Initial Settlement in writing. The provider may make the request with the filing of the cost report.
- A payment adjustment is necessary for several months of the cost report period, and the current date is beyond the cost report period end date.
- The review of a filed cost report identifies that the interim rate add-on amount, plant cost certification amount, or other special reimbursement interim amount included in the interim rate exceeds the amounts filed in the cost report.
- The provider has terminated Medicaid participation and has failed to file an acceptable cost report. An overpayment determination will be made for the payments to the provider during the period that cost report data is required for determining final reimbursement.

If the RARSS determines that the Initial Settlement is an underpayment amount to the nursing facility, additional payment will be made to the provider for not less than 70 percent and not more than 80 percent of the determined settlement amount due the provider based on a review of the provider's financial situation and the effect of the filed cost report data on the reimbursement settlement determination. Effective January 1, 2024, the nursing facility FY21, FY22 and FY23 Initial Settlement payment amount will be increased to 100 percent. All other parts of the FY21, FY22 and FY23 Initial Settlement process remain unchanged. Although the provider may request a review of the Initial Settlement amount, the Initial Settlement payment level percentage is not subject to appeal.

If RARSS determines there is an overpayment to the nursing facility, the SMA will recover the overpayment amount as outlined in the Medicaid Recovery of Overpayments subsection.

Before making any payment adjustment, the RARSS will notify the provider in advance using a Notice of Program Reimbursement letter. The provider is given 15 calendar days for review of the settlement determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer. A provider may request up to an additional 30 days to review an Initial Settlement. The provider must submit a written request stating the reason and the amount of the additional time needed (up to 30 days) for review. RARSS will review the request and notify the provider in writing of the approval or denial for additional time.

If the settlement action requires correction following the review, a new notification and review period will apply to the corrected settlement. After the period afforded the provider to review the Notice of Program

Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer.

The RARSS may process a Revised Initial Settlement for the cost report period if it determines that additional payment adjustment is necessary after processing an original Initial Settlement and before completing a final settlement. A Revised Initial Settlement will be completed when there are significantly more approved claims, rate revisions or errors in the prior determination and a final settlement action cannot yet be completed. The notification and payment processing actions identified with the original Initial Settlement procedures also apply to the Revised Initial Settlement process. The payment criteria will be applicable to the aggregate dollar amount of the Initial and Revised Settlements for the reimbursement period.

7.3 Final Settlement

The RARSS may determine that withholding of payment is necessary or that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. A retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After a cost report is audited, RARSS will determine if a Final Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Final Settlement uses the audited cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. Final Settlements determine if additional payment is due to the nursing facility or Medicaid.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

RARSS shares a Notice of Program Reimbursement with the provider through File Transfer. The notice explains the:

- Settlement adjustment(s) and the process prior to RARSS taking the payment action.
- Provider's appeal rights.

The provider is allowed 15 calendar days for review of the settlement determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer.

To obtain an extension, RARSS will review written requests from the provider stating the exceptional reason and the amount of additional time needed for the review (up to 30 calendar days). RARSS will review the exceptional circumstances stated in the request and notify the provider in writing of the approval or denial for additional time. If approved, an extended period of up to an additional 30 calendar days may be granted to the provider for review. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer.

If the settlement action is corrected following a review, a new notification and review period will apply to the revised determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer.

RARSS may process a Revised Final Settlement for the cost report period if RARSS determines that additional adjustments are necessary subsequent to processing the Final Settlement. The adjustment(s) will be processed if significant adjustments or errors exist in the prior settlement calculation. Notification and payment processes outlined in the Final Settlement process also apply to the Revised Final Settlement process.

7.3.A. Final Settlement Timeline

MDHHS shall issue a Notice of Program Reimbursement for a final settlement not more than 60 calendar days after the issuance of the Final Summary of Audit Adjustments Notice or no more than 60 calendar days after the Preliminary Summary of Audit Adjustments Notice becomes the Final Summary of Audit Adjustments Notice.

7.4 Depreciation Recapture Reimbursement Adjustment

If a provider has been reimbursed for asset depreciation expense in the Plant Cost Component and has sold the nursing facility assets, the sold assets may be subject to a depreciation recapture reimbursement adjustment in the reimbursement settlement for the cost report period in which the nursing facility assets are sold. The depreciation reimbursement adjustment uses reimbursement rates paid for services between October 1, 1984 and the date the facility was sold, or the date the Plant Cost Component of the per diem rate was converted to the tenure plant cost reimbursement method. (Refer to the Rate Determination Section of this appendix for additional information.)

The depreciation recapture adjustment is only applicable to the reimbursement rate periods the provider was paid a rate that specifically included depreciation expense in the Plant Cost Component of the Medicaid per diem rate. If the provider has never received Plant Cost Component reimbursement that specifically includes depreciation expense as a cost element of the rate calculations, the provider is not subject to the depreciation recapture reimbursement adjustment and is not required to complete the Medicaid Program Depreciation Recapture reporting.

A nursing facility provider that was reimbursed for depreciation in the Plant Cost Component and sells the nursing facility's assets must complete the Medicaid Program Depreciation Recapture reporting schedules for each applicable cost reporting year where depreciation was reimbursed. The Medicaid Program Depreciation Recapture schedule must be submitted with the cost report for the year that the asset sale occurs. Reporting schedules and instructions will be provided to the provider with the final period cost reporting request or may be requested from RARSS. The reporting schedules (Excel file) and completion instructions (Word file) are available in electronic format or hard copy format.

If the Medicaid Program Depreciation Recapture is not applicable, the schedules must indicate N/A (not applicable) and be submitted with the cost report filing. If RARSS does not receive completed reporting schedules, RARSS will apply a 100 percent depreciation expense reduction rate to calculations for each cost report period used to calculate the settlement.

The net depreciation reimbursement adjustment for each cost report year the provider was reimbursed by Medicaid will be included in the settlement calculation. The depreciation adjustment will be limited to the amount Medicaid reimbursed for depreciation expense in each cost report year. Plant cost reimbursement allowances will be included in the calculation of the depreciation adjustment, and may result in reducing the net depreciation adjustment if the provider had not previously qualified for the

incentive allowances prior to the depreciation reduction. The cost report reimbursement settlement notice will include the determination of depreciation recapture reimbursement adjustment.

7.5 Medicaid Recovery of Overpayments

Overpayment(s) due from a participating provider will first be offset against other settlements, payment adjustments, claims processing or any amounts due to the provider through lump sum or sequential installments until the overpayment amount is satisfied. If the provider is not participating in Medicaid, the overpayment amount must be paid to the State of Michigan for the Medicaid program immediately upon notification.

For recovery of overpayments during a CHOW, the successive owner will be held responsible for Medicaid overpayments, debts, and/or other liabilities regardless of sales agreement language between the successive owner and the preceding owner. Enforcement of sales agreement language is to be between the parties of that contract, and Medicaid will recover from the successive owner.

7.5.A. Request for Settlement Extended Payment of Schedule

If a participating provider alleges inability to repay the total overpayment amount in a lump sum or in sequential offset(s), the provider may request consideration for an extended repayment schedule. Extension requests for Settlement repayments must be received by RARSS within 15 calendar days of the Notice of Program Reimbursement date sent to the provider from RARSS. RARSS will notify the provider in writing of the decision. Requests received after 15 calendar days will be considered at the discretion of RARSS.

7.5.B. Criteria for Determining Extended Payment Arrangements

Extended settlement repayment schedules will only be considered if the net dollar amount of the current settlement notice reflects an overpayment amount of more than 10 percent of the provider's normal monthly Medicaid reimbursement payment(s). The provider's request must demonstrate that lump-sum recovery will create extraordinary financial hardship on the provider, and that the cash flow need of the nursing facility prevents the immediate repayment of the overpayment amount. Other factors that must not be present in creating financial hardship to the provider are significant expenditures for unallowable costs, ownership and management compensation exceeding Medicaid allowable cost limits, or significant dollar amounts for unallowable related party business transactions.

RARSS will share the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts through File Transfer. Requests for longer than three months will only be considered under exceptional circumstances, e.g., the monthly recovery schedule amount would be greater than 50 percent of the provider's normal monthly Medicaid reimbursement payment.

SECTION 8 - ALLOWABLE AND NON-ALLOWABLE COSTS

Unless stated to the contrary in this section, Medicaid allowable costs for nursing facilities are determined in accordance with provisions in the federal Principles of Reimbursement established for the Medicare program. This section does not propose to set reimbursement standards or reimbursement methodology. The focus here is the determination of allowable costs. Reasonable costs associated with nursing facility services included in the provider's per diem rate, as identified in the Coverages portion of this chapter, are allowable costs within the parameters of the Principles.

NOTE: Definitions for the principal terms used in this section may be found in the Definitions Section of this appendix. A copy of the cost report referenced in this section, completion instructions for the report and related information are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

8.1 ADVERTISING

Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective to increase patient utilization are not properly related to patient care and are not allowable. Examples of advertising costs incurred for a promotional objective include, but are not limited to, television ads, radio ads, restaurant placemats, billboards, and placing a facility's name on items without contact information. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.

8.2 APPRAISALS

Appraisal expenses incurred by providers may be allowable costs (administrative and general) if the appraisal is of assets related to resident care and if it meets the Medicaid Appraisal Guidelines. Expense for an appraisal of assets not related to resident care is not an allowable expense. Refer to the Appraisal Guidelines Section of this appendix for additional information.

8.3 ATTORNEY AND LEGAL FEES

The provider must maintain documentation and evidence of expenses incurred for legal fees and related costs as being related to the nursing facility's furnishing of patient care in order for such expenses to be allowable costs. Attorney fees are considered allowable costs incurred in the course of providing patient care, except as noted below.

Where MDHHS or the Centers for Medicare & Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable only in the following circumstances.

8.3.A. AUDIT FINDINGS AND RATE ACTIONS

- The provider prevails and the action is reversed.
  Example: The audit finding is not upheld and the audit adjustment or rate action is reversed.

- The provider prevails as defined by reduction of the contested audit finding by 50 percent or more.
  Example: An audit finding for an adjustment of $50,000 is reduced to $25,000.

8.3.B. Enforcement Actions

- The provider prevails and the action is reversed.
  Example: A DPNA is rescinded and does not go into effect, or when a provider is not in compliance before the effective date of the DPNA but succeeds in disputing the imposition and the DPNA is rescinded with no interruption in payment for the covered service.
- The period of imposition of a DPNA is reduced by 50 percent or more due to a change in the date that a nursing facility is determined to have been in compliance.
  Example: The length of a DPNA is reduced from 20 days to 10 days.
- The provider prevails as defined by reduction of a fine by 50 percent or more.
  Example: A Civil Money Penalty fine is reduced from $5,000 to $2,500.
- A federal enforcement action (F tag) is reduced in scope or severity.
  Example: An H-level citation reduced to a G-level citation, an F (SQOC)-level citation reduced to an E-level citation, or an Informal Dispute Resolution decision results in a reduction from an E-level citation to a D-level citation. Abatement of an Immediate Jeopardy or correction of a deficiency does not constitute a reduction.
- A state enforcement action is eliminated.
- A settlement agreement is reached between the provider and the state and federal government prior to a Hearing.

8.3.C. General Administration of the Facility

- Attorney fees incurred in connection with facility acquisition, mortgage or finance transactions are allowable if Medicaid determines the fees reasonable. The fees must be reported under plant cost and capital asset cost reporting. Legal expenses incurred relative to a nursing facility or capital asset acquisition are considered allowable if they are capitalized and amortized over the loan for up to a five-year period.
- Legal fees incurred in the process of securing financing or refinancing of facility loans must be amortized over the life of the mortgage.
- Attorney fees relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable cost.
- Legal and attorney fees associated with a legal settlement negotiated by the provider or court-ordered damages are allowable, provided the fees are not covered by any of the provider's liability insurance (examples of liability insurance include, but are not limited to, auto liability insurance, general liability insurance, professional liability insurance, etc.). The fees must also meet all other Medicaid and federal allowable cost principles and policies.

8.4 Bad Debts, Charity and Courtesy Allowances

Bad debts, charity, and courtesy allowances, as defined in the Medicare Principles, are deductions from revenue and are not allowable costs.

Bad debts are amounts considered to be uncollectable from accounts and notes receivable that were created or acquired in providing services. Charity allowances are reductions in charges made by the nursing facility provider due to the indigence of a resident. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the nursing facility, for services received by the provider.

Uncollected revenue for Medicare coinsurance and deductible billing amounts and patient payments for Medicaid eligible residents, and for non-covered services for Medicaid are not allowable costs.

8.5 Civil Money Penalties

Costs incurred for fines or money penalties for violation of federal, state, or local laws are not allowable.

8.6 Educational Activities and In-service Training

Medicaid has established credentials/requirements for educational activities to be recognized as allowable costs. Educational activities outside the continental United States are not allowable.

Approved educational activities are formally organized or planned programs of study engaged in by nursing facility providers in order to enhance the quality of resident care in a facility. These activities must be licensed where required by state law. Where licensing is not required, those presenting the educational activity must be recognized as a professional for the particular activity. Examples of allowable educational activities costs are:

- Part-time education for a facility's employee at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work to enhance the quality of medical care or the operating efficiency of the nursing facility.
- Costs, including associated travel expense within the continental United States, for employees to participate in educational seminars and workshops to enhance the quality of medical care or the operating efficiency of the nursing facility that does not lead to the ability to practice and begin employment in a nursing or allied health specialty.

The costs of the following in-service training activities are recognized as routine nursing care costs and are allowable costs:

- Orientation and on-the-job-training.
- Mandatory in-service education for Medicaid and Medicare certification.
- Maintenance of a medical library.
- Training of a resident or resident's family in the use of medical appliances.

Costs incurred for activities related to an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) are not allowed under routine nursing care, except as provided in the Medicaid

allowable cost and reimbursement policy outlined in the Cost Classifications and Cost Finding Section of this appendix.

8.7 Facility Vehicles and Travel

The cost of operating a facility-owned or leased vehicle must be adequately documented and differentiated between resident care use, business use or personal use. Only the costs for resident care and costs related to the conducting of facility business are allowable vehicle and travel costs. Use of a facility vehicle by facility personnel to commute from home to the facility and to return home at the end of the daily work period or other personal travel activity is considered personal use. Cost related to personal use travel activity is not allowable. Vehicle personal use is only allowable if the costs are reported employee compensation and satisfies Internal Revenue Service individual compensation tax reporting requirements.

The minimum documentation that must be retained and be available to auditors for all vehicles is:

- A Mileage log for each vehicle.
  - The log must contain at least the date, total miles for business use, name of driver, origination and destination, and the reason(s) for the vehicle use.
  - The log must report the monthly beginning and ending odometer reading.
- Business mileage and total mileage use of the vehicle to support the dollar allocation for determining allowable cost.
- Charge slips or invoices for fuel, maintenance, and other similar items.

If the reason for a trip is to transport a resident for medical care or treatment, the medical condition necessitating the trip must be documented. If the reason is to attend a seminar, convention, or meeting is related to nursing facility operation, invoices must document proof of attendance and mileage logs must be documented to identify the reason for the trip. Vehicle use for general business travel or other activity must include the reason in the mileage log.

Medicaid considers mileage that is not logged as not related to resident care or facility operation. The cost relating to unrecorded or non-supported as business use mileage is not allowable.

Travel by nursing facility personnel via personal vehicle use is an allowable expense if the travel is consistent with the aforementioned purpose criteria. Medicaid will allow such documented mileage at the State of Michigan, Department of Technology, Management & Budget (DTMB), approved private vehicle rate. The mileage rate includes all vehicle costs and is treated as a variable support cost. The approved private vehicle mileage rate information can be accessed on the DTMB website. (Refer to the Directory Appendix for website information.)

8.8 Interest

Interest is the cost incurred for the use of borrowed funds. Necessary and proper interest on both current and capital indebtedness is an allowable cost in accordance with Medicare Principles of Reimbursement. The allowance for interest expense is determined using one of the following principles:

- Allowable interest expense is determined in accordance with current Medicare Principles. Medicaid applies the following guidelines, although not fully inclusive, in determining allowable

interest expense. Interest expense must be reduced by all investment income, except where such income is from:

- Gifts, grants, and endowments held separately or pooled with other funds.
- Qualifying deferred compensation and/or self-insurance trust funds.
- Income from a provider's qualified pension fund.

- The rate of interest on a loan must not be in excess of what a prudent borrower would have had to pay in the marketplace at the time the loan was made.
- Interest expense, to be allowable, must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. Interest paid by the provider to partners, stockholders, or related organizations of the provider is, therefore, not allowable.

  Exception: A nursing facility operated by a religious order is allowed to borrow funds from the order and claim necessary interest expense for those funds.
- Interest on loans in excess of asset value acquisitions (after July 1970) is not an allowable cost. In a situation where the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess is not allowable.
- Interest expense applicable to borrowings principle balance for a nursing facility acquisition must be separately identified and reported from interest expense applicable to working capital or miscellaneous capital asset acquisitions (assets that are not part of or related to a facility acquisition). See Cost Finding and Cost Classifications for borrowing principle balance descriptions.
- Working capital borrowings are considered funds borrowed for 12 months or less to meet current normal operating expenses. For lines of credit, the borrowing shall be compliant with the 12 month requirement if the provider repays the entire amount withdrawn within 12 months of the date of the first draw. If the entire amount of the working capital borrowing is not repaid within 12 months, then all the interest expense associated with the borrowing is unallowable.
  - The loan must meet allowable cost principles. The rules on working capital borrowings do not apply to loans on capitalized assets. Interest on current indebtedness meeting the 12 month requirement and other program working capital criteria is allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable.
  - The nursing facility must document the need and due date for the working capital loan. The need must be to meet normal operating expenses and must be supported by an application of funds analysis demonstrating the use of loan proceeds for nursing facility expenses.
  - For the application of funds analysis, the provider must show that current cash receipts are not sufficient to meet the accounts payable, payroll, and other financial obligations. The provider must also demonstrate that the loan proceeds went directly into the appropriate cash account. The provider must document when each withdrawal was used, how each withdrawal was used, and how the funds are being applied to a purpose related to patient care. If the Home Office is the recipient of funds and intends to transfer funds to a provider under the Home Office, the provider must demonstrate the financial need for the funds, how the money was used, and how the use is related to patient care.

- The loan must include/require repayment of the principal balance within a prescribed period, including regular scheduled repayment amounts applying to the principal borrowings amount. The provider may repay the principal balance of the loan on a monthly, quarterly, or annual basis. If the provider repays the entire principal balance before the expiration of the loan term, the interest expense on that loan is considered allowable. If the provider has a line of credit, the provider must repay the entire amount withdrawn within 12 months of the date of the first draw for the interest expense to be considered allowable.

- Interest income is applied first as a reduction to mortgage related borrowing allowable interest expense, and then to other borrowings allowable interest expense.
- Interest expense is distinguished from penalty or finance late fees by the existence of a lender and borrower relationship pertaining to the financed amount. Penalty and finance fee assessments relating to late payment of liabilities are not considered borrowing costs and are not allowable.
- Interest expense includes the cost of finance charges associated with borrowed funds. If the interest expense on borrowed funds is allowable or unallowable, this would include any applicable finance charges. Finance charges include, but are not limited to, expenses related to the maintenance of records, account maintenance fees, related transaction fees, administration, etc.
- For loans issued on or after October 1, 2019, the minimum payment amount on the principal balance or a payment amount totaling at least 0.1 percent of the total outstanding loan balance, whichever is greater, must be made at least annually for any loan that has a loan period of greater than four years in order for interest to be considered an allowable expense. Refinancing of a loan or refinancing of multiple loans is not considered a principal balance payment, nor is a refinanced loan considered a new loan for purposes of this section. This includes when a short-term loan balance is paid off with borrowed funds, including bridge and balloon type loans.
  - For loans issued on or after October 1, 2019, if a provider is prohibited from making principal payments or is unable to restructure/negotiate the payment of principal, the Department will calculate allowable interest expense based on an audited amortization schedule with monthly principal payments of 0.1 percent of the declining loan balance amount.
  - Any loan costs related to obtaining or negotiating principal payment compliant loans will be deemed allowable and amortized for the life of the loan. Pre-payment penalties will also be allowable for the initial conversion to a loan with compliant principal payments and amortized for the life of the loan.
  - Loans that are refinanced into Federal Housing and Urban Development (HUD) loans are exempt from the principal payment requirement. If the loan is denied or the provider chose to withdraw from the Federal HUD financing process, all interest expense reported in the preceding years will be removed in the current audit year.
  - All related party loan costs, including interest expense, are unallowable regardless of any principal payment requirements.

8.8.A. Interest Class I and Class II Nursing Facilities

For the Class I and Class II facility, interest on borrowed funds related to the facility acquisition allowable interest expense is determined in accordance with the Principles in

effect on July 17, 1984, prior to the changes associated with the mandates of the DEFRA of 1984 and its limitations on the revaluation of assets.

- The dollar amount of facility acquisition financing is limited to the lesser of:
  - the purchase price of the nursing facility,
  - the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or
  - fair market value at the time of purchase; minus the purchase down payment.
- Interest expense on the dollar amount of a facility acquisition loan principle in excess of the financing limit is not allowable.
- Depreciated replacement cost is defined as the current reproduction cost adjusted for straight-line depreciation over the life of the asset.
- Depreciated replacement cost must be determined by an independent appraiser, chosen and paid for by the nursing facility provider, in accordance with the "Appraisal Guidelines" in the Principles.

Note: For Class I and Class II facilities that choose to forego increased reimbursement for interest expense, they must adopt the prior owner's financing and acquisition costs, interest expense schedule of borrowings, principal amortization, and interest expense recognized for reimbursement by the Medicaid program prior to the sale. Annual cost reporting must continue to be based on the prior owners.

8.9 Lease Costs

The Medicaid allowable cost provisions for asset lease transactions depend on the type of asset. Generally, asset lease transactions require that the lease expense be removed from cost and replaced by the underlying ownership cost of the property owner. Lease or long-term rental agreement (more than twelve months duration) transactions must be reported in the Medicaid cost report Statement of Leased Capital Assets. Cost reporting disclosure of lease costs is required to properly classify ownership costs for determining Medicaid reimbursement. There are also specific asset lease transactions that must be reported in the cost report statement but are an exception to the underlying ownership disclosure requirement. Specific types of lease expenses are discussed in the following sections.

Maintenance costs for leased capital assets, other than lease situations qualifying under "pass-through lease" criteria, are classified as variable costs. The nursing facility must determine and report these costs in the appropriate cost center or department. This requirement may necessitate the breakout of the maintenance costs for the lease contract.

Lease costs are differentiated from incidental or non-recurring rental expenses incurred to address a limited need of the facility. Rental expense incurred for incidental or limited time rental items, or non-recurring rental transactions, are allowable operating costs in the applicable cost center or department requiring the rental action. Limited time rental is considered as not longer than twelve months, non-recurring, and prohibits several/numerous sequential transactions for the same or similar rental items.

Exception: An extended period up to 24 months may be approved by RARSS in instances related to construction or renovation. The provider must submit an extension request to RARSS in writing at least

45 calendar days prior to the effective date of the extension. The request requires disclosure of item, duration, and action that precipitated the need to extend the project. RARSS will respond in writing.

8.9.A. Facility Lease

Cost reporting and reimbursement for capital assets relating to the nursing facility premises are under the same methods whether the items are owned or leased. For items to be considered allowable costs, the acquisition dates and asset costs, interest expense and other applicable ownership costs must be reported. Allowable lease costs are determined using one of the following principles:

- A nursing facility provider that entered into an acceptable, arm's-length lease prior to September 1, 1973, where the lessor has refused to open its books, is allowed an actual lease cost up to a maximum of $2.50 per resident day. This limit was developed from the average lease/rental costs for facilities leased prior to September 1, 1973, at which time the current method of calculation was effected. The pre-September 1, 1973, lessee has the right of appeal of an acceptable, arm's-length lease agreement for costs that exceed the $2.50 limit.
- A nursing facility provider that entered into, or amended, an acceptable, arm's-length lease agreement on or after September 1, 1973, is allowed a plant cost component determined in accordance with the Rate Determination section of this appendix, as applicable to an owner-provider, if the lessee discloses the allowable cost information required for rate setting. Leased assets are treated as though the lessor and the lessee are one and the same. Without full disclosure, lease expenses are not an allowable cost.

Interest expense allowed in the case of the lessor is also limited by Medicare Principles of Reimbursement. Further, interest income of the provider (lessee) is offset against all interest expense, including interest expense allowed on rental properties.

8.9.B. Plant Cost Lease Other Than Facility Space

Lease expense for nursing facility equipment or other activity that does not qualify for pass through lease expense is not allowable and must be reported utilizing the ownership underlying cost reporting requirement. If a lease is a virtual purchase and the lessee becomes the property owner at the termination of the lease, or for a nominal buyout amount, ownership cost reporting must be applied. The definition criteria of a virtual purchase are addressed in the federal Principles of Reimbursement.

Office space costs incurred in a home office or related party administrative service transaction are allowable under application of allowable depreciation, interest and property tax underlying ownership cost principles. Reasonable and necessary lease expenses incurred by a home office or related party for administrative services office space are allowable. Ownership underlying cost reporting is not required for leased business office space or similar leased space except in rental transactions involving a related party landlord. Related party transactions for office space are limited to ownership underlying costs applicable to allowable depreciation cost principles. The cost of office space is included in the cost of the home office or related party administrative services space cost and must be reported in accordance with Medicaid policy identified in the Cost Classification and Cost Finding Section of this appendix.

8.9.C. Plant Cost Pass Through Leases

A select group of rental and lease situations are exceptions to the requirement for disclosure of the underlying ownership costs. The lease or rental cost of qualifying items is allowed as plant cost in the lease rental cost classification to the extent that the asset use and cost is related to patient care. The pass through lease allowance applies to the following:

- Vehicle lease to a maximum of $425/month or $5,100/year, per vehicle
- Photocopiers
- Postage meters
- Telecommunications systems (including fax machines)
- Desktop or notebook computers and printers
- Parking lots and off-site record storage for rental from an unrelated party ownership and arm's length transaction

8.10 Life Insurance Premiums

Life insurance premiums are allowable when the premium is a fringe benefit for the insured employee when the beneficiary of the employee's insurance is not the provider. The cost of life insurance premiums for insurance on the lives of officers and employees, including provider-based physicians, is an allowable cost only within the provisions of Medicare Principles of Reimbursement.

8.11 Liquidation of Short-Term Liabilities

A short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The liquidation of liabilities requirement for Medicaid applies the federal Principles of Reimbursement for the determination of allowable costs. In instances where a nursing facility provider does not liquidate a short-term liability within the period specified in the federal requirements, the costs for the related goods and services are not allowed in the cost reporting period in which the liability was incurred, but are allowable in the cost report period when the liability is paid.

Exception to the one-year time limit to liquidate a short-term liability will be considered in accordance with the federal Principles of Reimbursement. A provider may request an extension for good cause to liquidate short-term liability. The provider must submit a written request at the time of submission of the Medicaid cost report to RARSS identifying the liability amount(s) and an explanation for the nonpayment of the liabilities and expected payments to liquidate the liability. RARSS will review the request and notify the Provider of the approval of an extension, not to exceed three years after the end of the cost report period that the request is filed, or of the denial of the request.

8.12 Lobbying and Political Activity Costs

A provider's costs incurred to support or oppose decisions of the federal Congress or state Legislature, costs related to campaigns for particular candidates or issues, and contributions to political action committees involving partisan elections are not allowable. Costs incurred, whether directly or indirectly through organization membership dues, fees or assessments, for these activities or to influence

legislation are not allowable. Contacts with federal or state agencies in the course of business operations of the nursing facility and general comment on proposed policies are not considered lobbying activity.

8.13 Maintenance of Effort Contributions by County Government

In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of that facility. The county government contributions to the nursing facility operations specifically due to the provisions of the Act, as amended, are not allowable costs of the county medical care facility Medicaid cost reporting.

8.14 Medical Supplies, Durable Medical Equipment (DME), Orthotics, and Prosthetics

The cost of medical supplies or DME are generally considered an allowable cost. However, the following items are not allowable and must be billed by the medical supplier:

- Air-fluidized beds
- Bariatric beds
- Bilevel positive airway pressure (BiPAP) device
- Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.
- Negative pressure wound therapy pump and accessories (wound VAC)
- Orthotics and Prosthetics
- Parenteral nutrition, including all supplies, equipment, and solutions
- Powered air flotation bed (low air loss therapy)
- Selected surgical dressings
- Shoes and additional components

The Nursing Facility Coverages chapter further describes the services included in the Medicaid per diem rate.

8.15 Membership Fees

Reasonable costs of memberships in professional, technical, or business-related organizations are allowable if the organization's mission or objectives are primarily related to resident care and/or long term care services activities. Costs of memberships in civic organizations for the purpose of implementing civic objectives are also allowable for Medicaid purposes (e.g., Chamber of Commerce). Any portion of membership fees used for lobbying, supporting political candidates and campaigning, or in social, fraternal, and other such organizations are not allowable. Awareness of an organization's ongoing lobbying and political activities requires identification of the portion of the organization's fees, dues, assessments or other allocations of costs to members or associated nursing facility providers. If an amount of non-allowable cost is not identified relating to this purpose, all costs associated with the fees or dues are non-allowable, unless the provider can document the appropriate unallowable portion.

8.16 Medical Director/Physician Services

The nursing facility must have a designated medical director that maintains responsibility for the implementation of resident care policies, for coordinating medical care, and is directly accountable to nursing facility management. The cost(s) applicable to the provision of the duties and responsibilities of the medical director is allowable routine nursing care. The nursing facility must maintain adequate records to document the level and type of services rendered by the medical director as a facility employee, or under a service contract or some other designated capacity. The cost(s) relating to the medical director duties and responsibilities must be distinguished from physician services activities that are not allowable routine nursing care. Refer to the Practitioner Chapter for discussion regarding physician services.

8.17 Non-Paid Workers/Volunteers

The value of services of non-paid workers is an allowable cost. The services must be performed on a regular, scheduled basis. The services must be of the type customarily performed by full-time employees and necessary to enable the nursing facility provider to carry out the functions of normal resident care and the operation of the facility. The value of services of a type for which providers generally do not remunerate individuals performing such services is not an allowable cost.

Example: Donated services of individuals in distributing books and magazines to residents, administering a provider canteen or cafeteria or a provider gift shop are not allowable/reimbursable.

8.18 Owner and Administrator Compensation

The cost for compensation to nursing facility owners is determined in accordance with Medicare Principles of Reimbursement, except the compensation to administrators, owner/administrators, or owners who function as administrators or assistant administrators, and corporate office executive management compensation is subject to specific dollar amount cost limits. Allowable cost limits are applied to nursing facilities based upon the bed size of the facility. Allowable cost limits are applied to individuals based upon the aggregate number of beds in nursing facilities being served or within the corporate organization. Compensation is remuneration to the individual for job performance and includes the costs of salary and wages, fringe benefits, director fees, and costs of services or items provided to the individual.

The compensation limit schedule is available on the MDHHS website. MDHHS annually adjusts the Owner/Administrator Compensation Limits to include cost-of-living changes as reflected by the United States Department of Labor Consumer Price Index for the metropolitan Detroit area. (Refer to the Directory Appendix for the website address.) Owner/Administrator Compensation Limits are expressed as facility annual compensation amounts and must be pro-rated on a monthly basis in situations where the cost reporting period is not 12 months.

8.18.A. Compensation Limit for Individual Nursing Facility

The allowable cost limit for compensation to nursing facility administrators, owner/ administrators, or owners who function as administrators or assistant administrators is determined according to the following criteria.

- Facility bed size includes licensed beds for nursing home, home for the aged and hospital services beds. Other categories of resident beds or housing arrangement beds are not included in determining the facility bed size for determining the appropriate compensation limit.
- The owner/administrator compensation limit used must coincide with the number of beds available for occupancy. The measurement criteria for determining the facility bed size is the number of beds available for resident or patient care at the beginning of the cost reporting period.
- Each nursing facility having 50 licensed beds or more must have a full-time licensed facility administrator. As required under State law, this individual is expected to be in the facility directing, conducting, or participating in activities directly related to the nursing facility during the normal 40-hour business week. A current position description that adequately defines the duties and responsibilities for the administrator position must be retained at the facility.
- The total compensation amount claimed for allowable costs for the facility administrator and related positions must not exceed amounts established by the SMA. These amounts are established by facility bed size: 1-49 beds, 50-99 beds, 100-149 beds and 150 beds or more.

The owner/administrator compensation limits apply to the costs for the positions of administrator, assistant administrator, and/or other administrative employees performing functions or having work responsibilities normally considered nursing facility administrator work activity. If an individual is functioning in a position that requires a nursing facility administrator's license, that person's compensation must be subjected to the limit. However, if a person does not have a license, but is performing the job functions and work activity of an administrator, that individual's compensation must also be included in the amount subjected to the limit. Inclusion of an individual's compensation in the total amount subjected to the limit is not only based on the individual having a license, it is also based on the job functions and work activity. Compensation paid by a related party or central office and charged directly to the nursing facility for individuals performing these activities must be included in the individual nursing facility compensation amount subject to the limit.

The compensation limit schedule does not apply to the salary of owners employed in capacities other than administration of the nursing facility provider's operation. The allowable salary level of an owner employed in a non-administration position cannot exceed the market value salary for that position, e.g., director of nursing, social services director. The allowable salary level must be commensurate with the amount of time the owner spends working in the non-administration position. If the owner also participates in facility administration, the portion of the payroll costs attributed to the administrative work must be included in the owner/administrator salary compensation and subject to the appropriate salary limits. The individual's administrative work must be appropriately documented with a position description and job responsibilities, and the allowable salary level for the administrative work must not exceed salary levels for similar administrative positions.

8.18.B. Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities

Where an individual is involved in the administration of more than one nursing facility, the maximum compensation allowed for allocation per facility and the allowable facility compensation is computed as follows:

- Total the number of beds, as defined in the individual nursing facility section, in all facilities served by the owner and/or administrator.
- Determine the appropriate compensation limit from the published schedule for the total number of beds.
- Compare the appropriate compensation limit with the actual allowable total salary and fringe benefits paid to the individual. The compensation limit is expressed as an annual amount (12-month period) and applicable to a full time position defined as a minimum of 40 hours per week committed to nursing home related management and administrative activity. Adequate work activity records must be available for verification of time expended for nursing facility related activity. Time commitment for less than full time requires the compensation limit be prorated to reflect the portion of time committed to this activity. Example, if 30 hours per week during an annual period is attributed to this activity, the adjusted limit for the individual is 75 percent of the appropriate compensation limit.
- The lesser of total allowable compensation or the compensation limit per the schedule is then allocated to all the facilities served by the owner and/or administrator based on a ratio of the number of beds in the individual facility to the total number of beds in all facilities served. The hours directly devoted to individual homes may be used as the allocation basis if verified by auditable records.
- Combine the allocated owner and/or administrator compensation with the allowable compensation of the facility's administrator/assistant administrator/co-administrator.
- Compare the combined compensation amount to the compensation limit schedule maximum allowable for the number of beds for that particular sized facility. The lesser of the facility's combined compensation or the facility's compensation limit is the allowable compensation to be used in the determination of allowable cost related to resident care.

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 400 beds, and the allowable facility compensation. The owner and/or administrator total compensation is $250,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2017. The compensation is $31,354 greater than the limit ($250,000 minus $218,646 equals $31,354).

Total number of beds in all facilities served	400
Compensation Cost Limit for 150+ bed facility as of 12/31/2017	$218,646
Owner and/or Administrator Total Compensation	$250,000
Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation)	$218,646
Amount of compensation not allowed	$31,354

Nursing Facility Bed Sizes	1-49 Beds	50-99 Beds	100-149 Beds	150+ Beds
Facility Compensation Limit 12/31/2017	$72,883	$121,471	$145,766	$218,646
Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	190
Allocation of Owner and/or Administrator Compensation[1]	$21,865	$38,263	$54,662	$103,857
Compensation of Facility Administrator	$40,000	$85,000	$95,000	$115,000
Facility Total Compensation to be compared to Limit[2]	$61,865	$123,263	$149,662	$218,857
Disallowed Compensation per Facility	$0	$1,792	$3,896	$211

1 The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/400 x $218,646.

2 Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

8.18.C. Compensation Limitation for Home Office Executive/Management

Salary and wages, fringe benefits and other related compensation costs for home office executive and management staff are included in the provider's home office cost report, and costs are allocated to the individual nursing homes and other business activities conducted by the organization. The allocation of the compensation costs is made to the operating entities of the corporation through the home office cost statement, and these costs are not included in the limit imposed on the individual nursing facility owner/administrator compensation.

The compensation limit for high-level management employees at the corporate home office level is enhanced to acknowledge increased scope of the business activity and corporate responsibility. The enhanced compensation limit is applicable in chain organization or related party management services situations where home office cost statement reporting exists, and full management oversight and administrative services are being provided to the nursing facilities and other business activities of the organization. Compensation costs for corporate office individuals under the enhanced compensation limit must be documented by a current position description, employment contract or other verifiable documentation that adequately defines the position, duties and responsibilities for the individual, and demonstrates the presence of services provided to the organization. Compensation to an individual employee of the corporate or central office, regardless of employment position or job activity function, is subject to the enhanced compensation limit to determine allowable cost. The enhanced compensation limit is expressed as an annual amount (12-month period) and is applicable to a full time position.

Employees paid by the corporate or central office but charged directly to the individual nursing facility for administrator or assistant administrator work functions at that facility are not eligible for the enhanced compensation limit. Allowable cost limits for such employees are addressed under individual nursing facility compensation limit.

The enhanced Medicaid allowable compensation for individual corporate office official and executive management employee personnel is applicable only to organizations greater than 150 beds. The enhanced compensation limit is based on the total number of beds owned and operated by and under full management control of the corporate organization and determined in accordance with the following schedule:

Number of Beds in the Chain Organization	Enhanced Compensation Limit
151 to 500 beds	100% of the 150+ bed facility limit
501 to 1,000 beds	120% of the 150+ bed facility limit
1,001 to 2,000 beds	130% of the 150+ bed facility limit
Over 2,000 beds	150% of the 150+ bed facility limit

The total number of beds includes all types of nursing home, home for the aged, hospital services, resident and other housing arrangement beds. If the business activity for the beds is not included in the allocation of the home office costs, the beds must not be counted for determining the number of beds in the chain organization. The 150+ bed facility limit used to determine the enhanced compensation limit amount is the MDHHS published limit for the year end corresponding to the reporting period end date of the home office cost statement.

8.19 Oxygen

Medicaid coverage of oxygen services for residents in nursing facilities is addressed in the Medicaid Services Descriptions Section of the Coverages portion of this chapter. The costs of oxygen gas, equipment, and supplies for intermittent and infrequent use are allowable in the routine nursing care cost and are included in the per diem reimbursement rate. Oxygen equipment rental costs for a limited period for purposes of providing this service are allowable in accordance with the incidental rental cost provisions addressed in the Lease Cost subsection of this appendix.

The costs of oxygen related services for frequent or prolonged use on a daily basis (i.e., at least 8 hours per day), regardless of payer source, is an ancillary services cost and is not an allowable routine nursing care cost. For residents requiring frequent and prolonged oxygen use who are in a nursing facility, the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility. For residents requiring frequent and prolonged oxygen use in a County Medical Care Facility or a Hospital Long Term Care Unit, the oxygen gas, equipment, and supplies must be billed by the nursing facility, not the medical supplier. These costs must be separately identified in the facility's accounting records or adequately compiled and verifiable for audit and excluded from Medicaid cost report routine nursing care unit cost.

8.20 Patient Transportation

The Transportation Section of the Coverages portion of this chapter addresses the nursing facility's responsibility to arrange or provide for non-emergency patient transportation. The cost for this transportation is a routine nursing care cost included in the nursing facility's annual cost report, and any reimbursement for the services is included in the routine nursing care per diem rate. Patient transportation costs are classified as support costs for Medicaid cost reporting.

The nursing facility must select the most efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service. Whenever possible, a facility-owned vehicle should be used. Costs relating to the nursing facility vehicle operation are addressed under the Facility Vehicles and Capital Asset Cost subsections of this appendix.

Costs incurred for contracted outside service for patient transportation must be included in the Medicaid cost reporting under the following reporting procedures:

- Administration and General Transportation – when the expense is not directly identified for specific residents or the care unit in which the resident resides in the facility; or
- Routine Nursing Care, Miscellaneous Support Cost
  - when there is only one routine nursing care unit in the facility and all resident transportation is for residents in that unit, or
  - when there are multiple nursing or residential care units in the facility, and the expense is directly identified by individual resident and location unit where the individual resides in the facility. Costs must be allocated to the corresponding nursing unit cost center identified in the Medicaid cost report.

8.20.A. Non-Emergency Ambulance

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider and cannot be charged to the beneficiary, beneficiary's family, or used to offset the patient-pay amount. The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.

8.21 Personal Comfort Items

The costs of services and items that do not contribute primarily to the resident's treatment of an illness or the resident's ability to function are not allowable. Direct costs, and the appropriate share of indirect costs, relating to such items as telephones, televisions and/or radios that are located in the patient's accommodations and furnished solely for the personal comfort of the resident, are not allowable. The cost of television and radio services furnished to residents generally is allowable if furnished in common use areas of the facility such as day rooms, recreation rooms or similar purpose area of the facility for the common benefit of facility residents. The cost of nurse-patient communications system that has no capability other than nurse and patient communication is allowable.

The costs of systems, including nurse-patient communications, television and telephone services, and similar items, may have the capability of providing residents with outside entertainment and providing nurse-patient communications. Only the cost of the component for nurse-patient communication is allowable routine nursing care. Direct distinction of cost related to the nurse-patient communication must be made for proper cost reporting, or an appropriate allocation must be established for Medicaid approval for the purpose of identifying the patient related and personal comfort related cost portions of combined systems.

8.22 Private Duty Nurses

Costs for nursing staff services provided by or under the supervision of a registered professional nurse are allowable; however, the costs of services of a private-duty nurse or other private-duty attendant are not allowable routine nursing care. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient under arrangement between the patient and the private-duty nurse or attendant.

A patient, or someone acting on their behalf, may arrange and pay for a private-duty nurse, or the nursing facility that initially incurs the requested costs may look to the patient for payment of the non-covered nursing facility service. Where the nursing facility acts on behalf of the resident, the services of the private-duty nurse or other attendant(s) under this arrangement are not allowable routine nursing care services regardless of the payment process to the private duty or other personnel or the control which the nursing facility may exercise with respect to the services rendered by the private-duty nurse or attendant.

8.23 Provider Donations for Outstationed State Staff

For cost reporting periods beginning prior to April 1, 2019, provider donations and administrative costs and incidental costs (workspace and telephone), incurred by the provider for outstationed staff are allowable costs. Costs are allowable to the amount contractually determined with the State.

For cost reporting periods beginning on or after April 1, 2019, provider donations for outstationed state staff and any associated costs paid to the State of Michigan for outstationed state staff are non-allowable costs. These costs must be reported on the provider's cost report and then adjusted from the cost report to be excluded from the rate setting process. A provider that utilizes an outstationed state worker(s) must submit a copy of their contract(s) for the use of that worker with their cost report.

8.24 Purchase Discounts

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. In addition, late charges on purchases are not an allowable expense. These would be in addition to regular costs authorized.

8.25 Rebates Larger Than One Year's Expense and Extraordinary Expense

Normal refund or rebate amounts are reported as a reduction offset to current operating costs in accordance with federal Principles of Reimbursement. A refund or rebate amount of previous years' allowable expenses must not be reported in total in the current fiscal year-end cost report where the refund or rebate amount pertains to more than one prior year reported expense. Likewise, extraordinary expense pertaining to more than one prior year must not be reported in total in the current fiscal year-end cost report. Refund or rebate and the extraordinary expense amounts pertaining to more than one prior year must be equally spread over as many subsequent years as the number of years represented by the refund or rebate or the extraordinary expense amount not to exceed three years. In the instance of a sale, the selling provider must include 100 percent of the remaining rebate balance in the final cost report. The apportionment will start in the cost-reporting year in which the refund amount is received or the extraordinary expense is discovered. These provisions are limited to Medicaid cost reporting requirements and do not change the applicable accounting principles for financial reporting.

8.26 Research Activities

The cost of research activities is allowable in accordance with Medicare Principles. If research is conducted in conjunction with, and as a part of, the care of residents, the costs of usual resident care are allowable to the extent that such costs are not met by funds provided for the research.

8.27 Routine Nursing Services

A provider's costs associated with the provision of necessary medical, nursing and mental health services, within the provisions of Medicare Principles of Reimbursement and requirements specified in the Coverages portion of this chapter, are allowable expenses. This includes costs incurred for meeting state federal requirements associated with specialized mental health rehabilitation services, e.g., monitoring the necessity for Annual Resident Reviews and coordinating or providing required services. The medical supply costs associated with routine nursing services and reimbursed by Medicare Part B are not allowable routine costs for Medicaid if the provider is reimbursed by Medicare.

8.28 Sick Leave

The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee is recognized as a fringe benefit and is included in allowable costs in the cost reporting period when paid. If the sick leave is vested and refunded, contributions to the fund are allowed under applicable provisions of the Medicare Principles. However, where the nursing facility provider's sick pay plan grants employees the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable, without funding, in the cost reporting period when earned.

8.29 Taxes and Fees

Taxes, including employee payroll taxes, sales taxes, and state imposed sales and use taxes, are allowable variable costs. The Michigan Business Tax and the Michigan Corporate Income Tax are allowable variable support costs.

8.29.A. General Taxes

Real and personal property taxes are allowable plant costs.

8.29.B. Quality Assurance Assessment Program (QAAP) Tax

A nursing facility's QAAP tax, including the Quality Measure Initiative (QMI) share of the tax, is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. The QAAP tax cost is adjusted through the cost reporting process to be segregated from use in rate setting. The QMI share of the QAAP tax must be reported on a separate account on the provider's cost report than the rest of the QAAP tax.

8.29.C. Fees and Assessments

Costs incurred for late payments, or for violation of federal, state, or local laws, are not allowable.

8.29.D. Penalty Taxes Under the Patient Protection and Affordable Care Act

Penalty taxes that may be assessed on employers under the employer-shared responsibility provisions in the Patient Protection and Affordable Care Act (PPACA) are not allowable costs used to calculate the Medicaid room and board rate. As such, the facility must remove these penalty taxes from allowable costs via a Worksheet 1-B adjustment.

8.30 Therapy and Pathology Services

A nursing facility provider must establish accounting procedures to reflect individual cost centers for reimbursable ancillary services, including physical therapy, occupational therapy, speech pathology and other services not classified as routine nursing care. Whether the therapist/pathologist is salaried, under contract, or an independent provider, a nursing facility provider must record Medicaid program payments as income and all expenditures for therapist/pathologist supportive personnel, equipment and its maintenance, supplies, and other costs directly attributable to rendering services in these cost centers.

The service is considered ancillary if the complexity of the service prescribed for the resident is such that it can be performed safely and/or effectively only under the general supervision of skilled rehabilitation personnel. Ancillary therapy services are evidenced by the presence of the following conditions:

- A written physician order.
- The skills of qualified technical or professional health personnel, such as physical therapists, occupational therapists, speech pathologists or audiologists, are required.
- Services are provided directly by, or under the general supervision of, the skilled personnel to assure the safety of the patient and to achieve medically desired results. General supervision requires that initial direction and periodic inspection of the actual activity is necessary.
- Services are rendered as part of an active treatment for a specific condition that has resulted in a loss or restriction of mobility or function.

Therapy services considered routine nursing care are services rendered under circumstances where the general supervision of exercises, which have been taught to the patient, can be performed repetitiously without skilled rehabilitation personnel. This includes maintenance programs where the performances of repetitive exercises, which may be required to maintain functions, do not require the involvement and services of skilled rehabilitation personnel, but may require the assistance of a trained nurse aide. Routine nursing care may include repetitive exercises to improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

The cost of the development of the maintenance plan when prepared by a licensed therapist is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to develop the maintenance plan. Medicaid considers maintenance plan development as routine nursing care included in the per diem rate.

The cost of the MDS assessment is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to complete the MDS assessment. Medicaid considers the MDS assessment as routine nursing care included in the per diem rate.

Depreciation for equipment and facility space assigned to these services must be included as an expense in the ancillary cost centers and computed in accordance with Medicaid guidelines for allowable depreciation. A uniform charge structure must be applied to the entire facility population receiving the services.

SECTION 9 - COST CLASSIFICATIONS AND COST FINDING

Medicaid-enrolled providers must develop and adopt a uniform Chart of Accounts that meets the minimum requirements established by Medicaid for classifying and reporting costs incurred in providing care to nursing facility residents. A nursing facility's accounting system will normally include more detailed accounts for recording facility costs. However, for cost reporting purposes, the detailed accounts are compiled into aggregate cost classification centers in accordance with program policies.

The following cost descriptions are guidelines to provide consistency in nursing facility provider cost reporting. Reimbursement classifications are identified for individual cost elements in examples available on the MDHHS website. (Refer to the Directory Appendix for website information.) More detailed discussions of cost categories are in the Allowable and Non-Allowable Costs section of this appendix.

9.1 NURSING FACILITY BED DAYS AND RESIDENT OCCUPANCY

A provider must report nursing facility bed days and resident occupancy statistics in the annual cost report. Policy related to facility census is presented in the Definitions section of this appendix. Specific attention should be directed to the following definitions: available bed, available bed days, ban on admissions, census, census day, denial of payment for new admissions, hold a bed day, leave day – hospital, leave day – therapeutic, occupancy, occupancy rate, per resident day cost, resident, resident days/occupancy, therapeutic leave day.

The nursing facility's resident occupancy statistics and cost reporting requirements will be significantly affected in cases where the provider requests, and is granted, approval for designating non-available beds as outlined in the Non-Available Beds subsection of this appendix.

9.2 VARIABLE COSTS – BASE AND SUPPORT

Variable costs include the total allowable base and support costs in a facility's routine nursing service units. A provider must allocate variable costs (support or base) depending on the activity for which the cost was incurred. The provider must also report direct costs for ancillary service costs and other non-reimbursable service costs. The direct costs incurred or attributed to these activities will not specifically be identified as base or support costs, however, the cost report cost finding process will allocate general services cost activities as base or support costs depending on the activity for which the cost was incurred.

9.2.A. BASE COSTS

Base costs cover activities associated with direct patient care. Major activities under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy and social services, food, linen (excluding mattress and mattress support unit), workers compensation, utility costs, consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments.

9.2.B. Support Costs

Support costs cover allowable activities not associated with direct patient care. Major items under these categories are payroll and payroll-related costs for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration, administrative costs, all consultant costs not specifically identified as base, all equipment maintenance and repair costs, purchased services, and contract labor not specified as base costs. Contract services costs for these departments are also support costs.

9.2.C. Base/Support Costs – Payroll Related

Nursing facility expenses related to payroll taxes and employee health and welfare are classified as base/support costs. These costs include fringe benefits such as employer contributions to FICA, FUTA, MESC, employee life and health insurance, retirement, physicals and all other insurance provided to employees as fringe benefits. If a nursing facility's accounting records do not separately reflect the payroll taxes and employee health and welfare expenses for "base" and "support" personnel by cost center identification, the total amount of these costs must be reported in the appropriate "base/support" cost category. Workers compensation is a base cost and not divided between base and support.

If the nursing facility's accounting system allows the allocation of costs to specific personnel or activities, the specified costs must be used on the cost report. If the nursing facility accounting system does not allow for this specificity, then a reclassification of costs must be made to the appropriate service areas. In these cases, it will be necessary to reclassify such costs on the basis of salary and wage costs distribution.

9.2.D. Base/Support Costs – Contract Services for Direct Patient Care

A provider that purchases direct care services as an alternative to employing personnel may apportion the contract services costs between base and support cost by applying the industry-wide average base-to-variable cost ratio. The nursing facility must appropriately report these costs in the annual cost report. Medicaid reviews the industry-wide average base-to variable cost ratio annually and revises it if a difference of two percent or greater exists between the current calendar year cost report aggregate average industry data and the previously promulgated industry-wide base-to-variable cost ratio. If a revision is applicable, the revised cost ratio will be effective for subsequent year cost reporting.

9.3 Plant Costs

Plant costs include depreciation, interest expense (either working capital or capital indebtedness), real estate and personal property taxes, amortization costs associated with loan financing costs (amortization of legal fees, recording fees or other fees relating to the capital asset acquisition points, letters of credit), and specific lease expenses.

9.4 Capital Asset Expenditure

Medicaid limitations on capital expenditure costs are determined in accordance with Medicare Principles except as modified by Medicaid policy.

A nursing facility provider anticipating capital expenditures should contact the CON Evaluation Section to make application for a CON. (Refer to the Directory Appendix for contact information.)

If a CON is approved, the provider may be eligible for increased reimbursement, subject to Plant Cost Component limits. If a new capital expenditure required CON review and was denied, the provider's reimbursement rate must exclude the costs of the denied capital expenditure. The provider's cost report must identify capital expenditures approved and denied by CON.

The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two years and a historical cost of at least $5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. If the provider's capitalization policy sets lower thresholds than Medicaid, then the provider's established policy must be followed for cost reporting. A provider may not have separate capitalization policies for Medicaid cost reporting and for other financial statements and reports.

Assets that are acquired as part of an integrated system must be considered as a single asset for capitalization purposes. Assets that have a stand-alone functional capability may be considered on a single item basis. Individual asset items that do not meet the dollar and useful life threshold are classified as minor equipment and will be reported as minor equipment expense in the cost report of the year of acquisition.

Example: An office workspace with connecting portions dependent upon other portions for support and stability; a communication system installed in the facility and in resident rooms to allow the full functioning of two-way communication system.

Repair and improvement costs related to assets that result in extending useful life or increased productivity must be capitalized for Medicaid if they are capitalized under Generally Accepted Accounting Principles. Providers must demonstrate consistency in financial reporting.

Providers must follow Generally Accepted Accounting Principles (GAAP) in reporting repairs to capital assets. Repairs that should be capitalized under GAAP must not be an expense item on the cost report.

9.4.A. Capital Asset Cost Data for Class I Facilities

9.4.A.1. Capitalized Asset Acquisition Costs

Capitalized asset acquisition costs are used to determine the Current Asset Value for the Plant Cost Component in the Class I nursing facility reimbursement rate. The Medicare Principles of Reimbursement are used to determine the acquisition costs allowable to the original provider/owner of the asset. The SMA uses only the acquisition cost incurred by the original owner to determine the capital asset value cost data. Asset acquisition costs are allowed for related party transactions in accordance with Medicare's interpretation for costs to related organizations.

The cost basis for capital assets is the CAV value determination of the original owner's audited historical acquisition cost. It is the responsibility of the current owner to provide the audited historical cost and purchase year of the original owner; otherwise, the assets are assumed obsolete for payment determination purposes, i.e., of no current asset value. The current provider must annually report the cost and the applicable year's depreciation for newly purchased assets and value changes to previously acquired assets. Cost reporting for asset acquisition costs related to a capital asset that is traded-in for a new replacement item must also report the value of the capital assets.

Capital costs related to assets that are no longer used in the facility operation and assets that are not necessary for resident care, e.g., excessive land not allowed under the Principles, are not allowable in the nursing facility capital asset value cost data.

To ensure that Medicaid does not pay for assets that are no longer being used to provide resident care, the original acquisition costs, or an estimate thereof, are removed from the current capital asset cost data. The costs of retirement or replacement of buildings, building improvements, building additions, fixed building equipment, land improvements, or movable equipment are removed from the capital asset cost data for the corresponding year of the original acquisition of that retired or replaced asset.

When the original value can be ascertained through such methods as component part depreciation records, the provider must remove the original costs of the retired or replaced assets from the year of the original acquisition, and report the new asset item cost for the year purchased.

Building components, building services equipment or other fixed equipment assets or land improvements may have historically been included within the asset price of the building to which they are attached and, as a result, are not separable for purposes of calculating depreciation or the capital asset cost data. However, in the determination of the Current Asset Value, an asset must exist in the nursing facility for it to have a value. Therefore, if a fixed asset has been retired or replaced and the asset cost cannot be determined from the provider's Medicaid/Medicare asset cost schedule, construction records, or tax records, the provider must determine and report the original asset cost based on the cost of a similar asset.

If a nursing facility provider is unable to report the original asset cost by either individual asset cost or component basis, the new asset will be assumed as a replacement of a similar asset for determining the necessary revisions to the capital asset cost data using the asset trade-in provisions.

When a capital asset is traded-in for a new replacement item, either the original owner's cost or a derived value of the item traded in is removed from the capital asset cost data. The purchase price of the new asset, prior to consideration of the value of any trade-in, is added into the capital asset cost data for the current year of purchase. If the original cost of the item is unknown, the provider must derive a value by backdating the purchase price amount for the new replacement asset. If the asset being replaced is of a different quality or type than the new asset, the amount to be backdated may be based on the expected current cost of a similar asset of like quality and type. The derived value calculation is made by applying a construction cost index (exclusive of the annual obsolescence adjustment) to the value of the new asset item cost, then subtracting the

derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and the derived application process used for nursing facility cost reporting can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Capital assets that are leased or rented are treated as obsolete assets for rate determination purposes when the underlying historical acquisition cost to the original owner has not been disclosed, or when the underlying information cannot be verified through audit.

Capital assets recorded in the central office, home office, or related organization financial records that are identifiable to a specific nursing facility are included in that facility's capital asset cost data determination process. The asset values, interest, and property taxes identified with these assets must be charged directly to the nursing facility and will be reimbursed in accordance with the applicable policy.

Costs of capital assets associated with the operation of related organizations are not included in the capital asset cost data determination for a specific nursing facility. The plant and variable costs of such organizations are treated as purchased services. (Refer to the Variable Costs – Base and Support subsections for discussion regarding purchase and contract services.)

9.4.A.2. Exceptions to Asset Acquisition Cost Capitalization

Exceptions to the acquisition cost basis for assets may be allowed in the following situations:

- For the occasional purchase of used, movable equipment for ongoing nursing facility operations when the purchase is not related to a change in facility ownership. For the purchase of used replacement equipment, e.g., re-manufactured beds, a used lawn tractor, or used vehicles, the asset acquisition is treated as if new items were purchased. The allowable cost of acquisition is included in the year the asset is put into service by the current purchaser.
- For the nursing facility land value. The land value to be included in the Current Asset Value is based on the current owner's allowable acquisition cost determined in accordance with Medicare Principles, and not to exceed the amount reported to the Internal Revenue Service for federal tax purposes. The cost of the prior owner's land improvement asset, which is an integral part of the nursing facility land component and is included in the new or current owner's land acquisition cost, must be excluded from the historical capital asset cost data. The current facility ownership capital asset cost data cannot include both the land purchase price and the original owner's land improvement cost data.
- When equipment is purchased as "used" equipment as part of a facility change of ownership, or only a change of ownership of the facility equipment has occurred, the prior owner's (seller) computation of value at the time of sale is continued to the new owner.

9.4.B. Capital Asset Categories (Fixed Assets)

Capital asset classifications and asset useful life for depreciation purposes are determined in accordance with the American Hospital Association (AHA) guidelines in effect at the time of the asset acquisition.

General descriptions of the asset cost categories for cost reporting are:

Land – includes the land owned and used in the provider operations and includes off-site sewer and water lines, public utility costs necessary to service the land, government assessments for street paving and sewers, cost of permanent roadways and grading of a non-depreciable nature, cost of curbs and sidewalks where the replacement is not the responsibility of the nursing facility, and other land expenditure of a non-depreciable nature.

Land Improvement – improvements of a depreciable nature including paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the nursing facility.

Building – includes the basic building structure, shell or frame, and additions thereto, building components, exterior walls, interior framing, walls, floors and ceiling, architectural, consulting, and interest expense associated with new construction or acquisition.

Building Improvement – includes building equipment attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of fixed equipment are: (a) attached to or installed in the building structure, and (b) fairly long life but may be less than the building.

Leasehold Improvement – includes betterments and additions made by the lessee to the leased property, whereby the improvements become the property of the lessor after expiration of the lease. These items generally meet the requirements of building improvement assets.

Department Equipment – includes assets generally assigned to a specific department within the nursing facility with relatively fixed location but capable of being moved; as distinguished from building equipment. (Refer to Building Improvement.)

Furniture and Fixtures – includes assets similar in characteristic to department equipment, however, normally with no fixed location or used by various departments within the facility.

Transportation Equipment – includes vehicles used in conducting nursing facility operations relative to resident transportation, plant operations and maintenance, or general means of transport.

Capital asset costs incurred by a landlord who is leasing facility assets to a provider must be disclosed and reported in the provider's annual cost report. Capital asset cost reporting and allowable cost policies are applicable to the reporting of the leased assets in the same manner as if the assets were owned by the provider.

9.4.C. Depreciation

Class I and Class II nursing facilities are under the tenure plant cost reimbursement methodology, and potential reimbursement is not based on depreciation expense for the nursing facility capital assets. The costs of services provided from home office or related party transactions, other than for capital assets related to the nursing facility physical plant, may include depreciation expense for asset costs applicable to the operations of the home office or related party business. Allowable depreciation costs for the home office or related party will be determined in accordance with Medicare Principles. These costs will be included in the home office or related party administrative services space costs and must be reported in accordance with Medicaid policy identified in the Related or Chain Organization Cost Allocation subsection of this appendix. Class III and Class IV nursing facilities reimbursed under the depreciation plant cost reimbursement methodology will have depreciation costs determined in accordance with allowable cost principles defined in this policy. The allowance for depreciation is determined in accordance with Medicare Principles except that only the straight-line method of depreciation may be used. The historical asset cost basis and the depreciation basis for nursing facility sales is subject to the limitation on the valuation of assets mandated by the Medicare Principles.

In addition to the depreciation standards in the Medicare Principles, Medicaid also requires adherence to the following standards:

- Consistent use of either component or composite asset depreciation schedules. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased, existing facility.
- All abandonment losses are considered as a depreciation expense item.

9.4.D. Disposal of Depreciable Assets

9.4.D.1. Class I Nursing Facilities

Class I nursing facilities will account for asset acquisition and disposal in accordance with the Capital Asset Cost Data for Class I Facilities subsection of this appendix.

A Class I nursing facility purchased on or after March 31, 1985 is not subject to depreciation adjustment. In the event of a sale, the assets of Class I facilities whose ownership began prior to March 31, 1985, amounts included in the Medicaid per diem rate as an explicit depreciation expense item are subject to recapture in the event of a gain on the disposal of assets. The selling Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal year cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment subsection of this appendix for additional information.

9.4.D.2. CLASS III NURSING FACILITIES

Class III providers whose Medicaid rate includes depreciation expense must adhere to the Medicare Principles of Reimbursement to account for the disposal of depreciable assets. If the disposal of depreciable assets in the reporting year results in a gain or aggregate loss below $5,000, the adjustment will be made in the nursing facility provider's current year cost reporting allowable cost. The allowable gain is limited to the amount of depreciation previously included in the provider's allowable costs for the disposed assets.

In the event of a sale of the entire nursing facility and the termination of Provider participation in the Medicaid program, the terminating Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal period cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment section of this appendix for additional information.

9.5 LOANS/BORROWINGS BALANCE REPORTING

Necessary and proper interest on current and capital debt is a Medicaid allowable cost. All interest expense, whether on current or long term debt, is classified as a plant cost. Determination of allowable interest expense will be in accordance with Medicare allowable cost principles. However, there are reimbursement limits for determining the Plant Cost Component specific to Medicaid which are addressed in the Rate Determination section of this appendix.

Medicaid requires nursing facilities to report the loans and borrowings balance in the annual cost report. The cost report instructions identify the schedules that must be used to report borrowing principle balances. The nursing facility must report the beginning balance and monthly end balance of outstanding allowable loans and borrowings for the period corresponding to the cost report year. The loans and borrowings in the borrowing balance report must only include the outstanding loans or other liability obligations for which the nursing facility is claiming interest expense related to that borrowing principle. If the nursing facility is filing a cost report claim for interest expense as an allowable cost, the nursing facility must document the corresponding borrowing obligation related to the interest expense. The outstanding borrowing balance is defined as the allowable borrowing principle amount on which the interest rate, normally expressed as an "interest rate percentage", is applied for the purpose of calculating the interest expense applicable to the specific cost report period.

Loans from related parties or unallowable borrowings must be excluded from the cost report borrowing balance schedule. The interest incurred on excluded borrowings must be removed from incurred interest costs in a like manner. Interest income or investment income which is required to be offset to interest expense in the cost report period must not be considered a reduction in the outstanding borrowing balance principle.

Mortgage principle balances or similar finance arrangements for the purpose of nursing facility or business acquisition must be separately identified from other loan balances in the cost report borrowing balance schedule. Examples of other loan balances include working capital and miscellaneous asset acquisition purpose loans. In the event of refinancing and co-mingling of separate loan balances into a single finance arrangement, the nursing facility must identify the appropriate portions of the combined financed amount used for different purposes and maintain the separation for cost reporting. Likewise, multiple loans for the same purpose must be combined for the appropriate category for cost reporting.

Borrowing principle obligations incurred by a home office must be reported on the individual nursing facility cost report borrowing balance worksheet only for loans directly associated with financing the individual nursing facility asset purchases or facility acquisition costs. The interest expense applicable to such loans must also be identified, directly charged to the individual nursing facility, and reported as interest expense for the nursing facility. Working capital and other loans incurred directly under the home office operation and not related to nursing facility acquisition are considered general administrative costs and are included, to the extent determined necessary and reasonable, in the home office cost allocation to the individual nursing facilities and other business operations of the corporate chain.

Allowable outstanding loan balances of landlord entities that are leasing nursing home facility assets to a provider must be disclosed and reported in the provider's annual cost report. Borrowings balance cost reporting and allowable cost policies are applicable to the reporting of the underlying cost of the landlord entity in the same manner had the borrowings been recorded on the financial records of the provider.

9.6 Cost Finding

Cost finding is the process of recasting the data from the accounts kept by a provider to determine the cost of services rendered, allocating direct costs, and prorating indirect costs in accordance with Medicare Principles of Reimbursement, except where modified by Medicaid policy. Medicaid determines reimbursement rates for nursing facility providers based on specific categories of cost, as addressed in other sections of this appendix.

9.6.A. Cost Allocation Basis

The Medicaid cost reporting process establishes the cost finding process. Indirect and non-revenue producing cost centers are allocated using a statistical basis that reflects an equitable measurement of the services provided to, or benefits derived by, a revenue producing or non-reimbursable activity. The nursing facility must develop and maintain adequate statistical data to corroborate the basis of the cost allocation. Adequacy requires that the data be accurate and include sufficient detail to accomplish the purpose for which it is intended. When completing the allocation of the general service cost centers, the nursing facility provider should first allocate those cost centers that render the most services to, and receive the least services from, other cost centers.

9.6.A.1. Facility Square Footage and Space Reporting

A facility space cost allocation is based on square footage identified with specific service areas or activities occupying and using that space. Square footage is an allocation base that may be applicable for multiple indirect cost center activities. However, for cost centers where the basis is the same (e.g., square feet), the total statistical basis over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been allocated.

A consistent and uniform process must be used by the nursing facility for compiling and charging the square footage to each service activity that is primarily benefiting from or using that space. Facility space that is used for multiple activities must be documented and connected to each applicable activity based upon current data that reflects actual use and is available for audit verification. Hallway space located within a specific department or service area is considered usable space for that department. Areas of the

facility for general use, such as connecting hallways, reception areas, lobby, and elevator, used or benefiting all service activities are considered common space. Identifying and counting common space must be consistent for all service areas of the facility.

For example, common space in one service department cannot be excluded from space allocated to that service activity, while similar common space located in other service departments is included in the space allocation of other service activities. The allocation basis must apply either the gross method, where all common area is included and charged to the specific services activity, or the net method, where common space located within the identified service area is not charged to the service activity. The nursing facility's handling of common space area in the cost report allocation must result in equitable distribution of costs associated with the common space to appropriate activities. A change in the process or methodology that the nursing facility uses for allocating space is a change in allocation basis, so appropriate notice and a request must be made to the SMA.

9.6.A.2. Ancillary/Therapy Services Space Reporting

Facility space used for ancillary services delivery must be identified and charged to the appropriate ancillary services cost center. For example, space used for skilled rehabilitation services provided based on a physician's order must be allocated to the appropriate ancillary cost center.

Accounting procedures must be established and implemented to reflect individual cost centers for reimbursable therapy and pathology services. Irrespective of the therapist or pathologist's status as an employee, contractor or independent provider, the nursing facility must record all charges as income and all expenditures for supportive personnel, equipment and its maintenance, supplies and other costs directly attributable to reimbursable expenses in these cost centers.

9.6.A.3. Ancillary/Therapy Services Administrative Overhead

Medicaid requires that administrative overhead associated with ancillary services be allocated to the ancillary services cost center. The required basis for distribution of administrative costs to the benefiting activities of the nursing facility is accumulated costs. The accumulated costs base generally includes all service activities of the nursing facility.

In specific situations, the nursing facility may request exclusion of certain ancillary service groups from the administrative cost overhead allocation in the Medicaid cost report. The determination applies only to those service items where the billing to the third party only allows for the recovery of the direct cost of the service. The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare Principles of Reimbursement and that it is not incurring additional costs beyond the activity for arranging for the services. The incidental costs for inclusion of the ancillary service bill preparation must be as follows:

- The facility representatives arrange for the services to be performed by an agency or entity that is not part of the nursing facility operation.
- The nursing facility is not directly involved in providing the ancillary service.
- The nursing facility does not incur any costs for supplies and equipment necessary to perform the service.
- The ancillary service is being recorded through the accounting records and billing system of the nursing facility for the consolidated billing of the services provided to the nursing facility resident.
- The nursing facility does not have physical space dedicated for the purpose of delivery or rendering of the ancillary service. Dedicated space is considered space that is used predominantly for the purpose of the ancillary service delivery.
- The nursing facility is not charging a mark-up related to the billing of the service.

If the nursing facility is allowed to bill for, or recover revenue in excess of, the direct cost of the services, the statistical and fiscal worksheet of the cost report may be adjusted to reflect the revenue received. The amount of revenue exceeding the direct cost will be considered the overhead amount that must be reflected as an adjustment to the "miscellaneous expense" in the Administrative and General cost center, in addition to the direct cost adjustment to exclude the ancillary service cost from the cost allocation step-down. The nursing facility must demonstrate that the excess revenue is a fair representation of the overhead cost or activity associated with providing the service. If this requirement is not met, the ancillary services activity must be included in the administrative cost allocation basis for the apportionment of overhead to the activity.

9.6.A.4. Ancillary Group Exclusion

A provider may request an ancillary group exclusion. The exclusion request must be approved by RARSS. The request must include the parameters under which the exception is requested. If the request is approved by RARSS and it is later determined non-applicable, the exclusion is void for that entire cost report period.

9.6.A.5. Change of Ownership – Exclusion Request

If a CHOW occurs, the prior owner's ancillary group exclusion is no longer applicable. The new owner may submit an ancillary group exclusion request to RARSS for approval. The exclusion process is outlined in the Ancillary Group Exclusion subsection of this appendix.

9.6.B. Change in Cost Allocation Basis

A provider who wishes to change the allocation basis for a particular cost center, or the order in which the cost centers are allocated, must submit a written request to the RARSS. (Refer to the Directory Appendix for contact information.) The request must include reasonable justification and supporting documentation that the new basis is more accurate and appropriate for allocation of the cost activity for Medicaid reimbursement determination. The request must be made prior to the beginning of the cost-reporting period in which the change is to apply. The effective date of the change will be the

beginning of the cost-reporting period for which the request has been made. Failure to submit a timely written request will result in an audit adjustment. The nursing facility provider must maintain both prior and proposed statistics base data until the change is approved.

Medicaid may reject a submitted cost report if a request to change the allocation basis has not been submitted and approved by RARSS. If the previous allocation basis methodology has not been maintained for the current year, Medicaid may accept previous year's statistics for the current year cost reporting.

9.6.C. Related or Chain Organization Cost Allocation

The Medicare Principles of Reimbursement define a related organization as an organization linked to a nursing facility provider by common ownership or control, including a chain organization. Medicaid extends an option for cost allocation for related or chain organizations. An immediate family relationship establishes an irrefutable presumption of relatedness.

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization. To the extent that the home office furnishes services related to patient care to the nursing facility, the reasonable costs of the services are included in the nursing facility's cost report. Medicaid policy for related organization costs is determined in accordance with provisions in the federal Provider Reimbursement Manual for related organization costs. Exceptions to the application of federal provisions are addressed in the Cost Classifications and Cost Finding and the Allowable and Non-Allowable Costs sections of this appendix.

Home office costs apportioned to individual nursing facilities through the Home Office Cost Statement are classified as support costs. Cost report requirements for home office are addressed in the Cost Reporting section of this appendix.

Costs incurred by a nursing facility for services furnished by a related organization are allowable. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable to the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization.

The operating costs of a related ownership organization are allocated to an individual nursing facility as a "purchased service" and must be identified within the appropriate cost center for Medicaid cost reporting. The type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility. Refer to the Cost Classifications and Cost Finding section of this appendix for additional information.

For cost reports where the home office and the individual nursing facility's fiscal year ends are different, a provider must elect to forego the inclusion of an allocation of the

current year's home office costs in the current year's individual provider cost report. A written request must be submitted annually to RARSS, with the individual provider's cost report signed by the appropriate corporate official acknowledging that the cost report is being submitted with the prior fiscal year's home office costs. The written request must also indicate that the corporation is waiving the right to inclusion of any allocation of the current year's home office costs in the current year's individual provider cost report.

For example, a home office fiscal year end (FYE) is December 31 and the individual facility's FYEs are May 31, August 31, September 30 and December 31. For individual facility cost reporting for fiscal year 2018 ending in May, August, September and October, the individual facility must elect to report only the home office costs from the FYE December 31, 2017 home office cost report. The home office allocation of costs from FYE December 31, 2017 to the individual facility would be reported and audited. During the audit of the individual facility cost report, adjustments to allocate actual FYE December 31, 2018 home office costs would not be made. For individual facilities with FYE December 31, 2018, the home office costs from the FYE December 31, 2018 cost report would be reported.

9.7 Distinct Part Unit Reporting

For reimbursement purposes, the Nursing Facility is defined as the unit that is certified for participation in the Medicaid program, whether that unit comprises all of, or a distinct part of, a larger institution.

Certification regulations require that a distinct part be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The provider must demonstrate to Medicaid that the system used for recording the hours of nursing services can be audited and equitably allocates the nursing services costs between the distinct part and other parts of the facility. The nursing services costs are only the gross salaries and wages of nursing and related personnel, such as RNs, LPNs, and CNAs. Costs applicable to general services areas of the institution must be allocated in accordance with the Cost Finding section of this appendix.

Nursing services costs allocated to that distinct part of the facility must relate only to services provided to those residents. While a provider may choose the record keeping method used to allocate these costs, the system must be capable of accurately reflecting the hours of nursing service applicable to the distinct part and other parts of the institution. Various systems may be employed to record and accumulate the hours of nursing services such as actual time spent taken from payroll records, assignment schedules, sign-in sheets, etc. Providers wishing to use any other method that does not identify actual time must obtain written approval from the RARSS prior to changing its cost allocation method. The request must identify the reason for the change and must demonstrate that the proposed method is representative of actual nursing staffing within the facility and results in an equitable and accurate allocation of nursing services costs.

A nursing services cost allocation alternative may be applied only with the prior written permission from RARSS.

An institution may have more than one Medicaid distinct unit in specific cases where Medicaid has certified beds as special use for specialized nursing care. The specialized nursing care beds must be physically distinguishable, within a designated area, and identified as a separate nursing bed class for Medicaid reimbursement. Requirements for reporting nursing services costs also apply to nursing

services for residents in specialized nursing care beds. The nursing facility must have prior approval from Medicaid for participation in a program for specialized nursing care.

9.8 Day Care Services Provided in the Nursing Facility

According to federal principles, day care services provided to an employee's dependent are not a fringe benefit when furnished for the convenience of the provider. Medicaid considers day care services provided to an employee's dependent a convenience to the provider due to potential support of staff recruitment and retention.

9.8.A. Employee Dependents

According to federal principles, the costs of operating a day care center for the children of a facility's or related facility's employees must not be reported as an employee fringe benefit. The costs are allowable to the extent that the amount is reasonable. "Reasonableness" means that the services are provided in accordance with the policies and regulations established for the provision of such services and must take into account both direct and indirect costs. The provision of services must also be considered reasonable in that the costs of operating a facility demonstrate sufficient benefits. For example, the number of children participating justifies the provision of services.

Total cost must not exceed what a prudent and cost conscious buyer pays for like services. If costs are determined to exceed such level and the nursing facility cannot provide clear evidence that the higher costs were unavoidable, the excess costs are not allowable. The day care center operations must be provided in accordance with, and satisfy applicable regulatory requirements governing the operations of, such activities. The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

The following costs are non-allowable:

- diapers
- towelettes
- lotions
- oils
- similarly used hygiene products

9.8.B. Services Provided To Non-Employee Dependents

If a provider renders services to non-employee dependents, the day care center must be established as a separate entity even if services are also provided to employee dependents. Medicaid will allow costs relative to intergenerational activities as an offset when the day care center suffers a financial loss, which is limited to the lesser of total documented intergenerational activities or the amount of the loss. Intergenerational activities must be documented, organized activities between the children attending the day care and the nursing facility residents.

The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

9.9 Nurse Aide Training and Competency Evaluation Program (NATCEP) and Competency Evaluation Program (CEP)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990 requires that any nurse aide employed in a nursing facility complete a competency evaluation program. Medicaid will reimburse a Medicaid certified nursing facility for the Medicaid share of allowable costs directly related to meeting the nurse aide training and competency evaluation requirements. Reimbursement includes only costs incurred with a NATCEP or CEP approved by the SSA. Medicaid reimbursement applies only to Certified Nurse Aides (CNA) working in a Medicaid certified nursing facility and are not available to CNAs in other residential or patient care settings.

A nurse aide who is employed by a nursing facility or who has received an offer of employment from a nursing facility on the date on which the nurse aide begins a NATCEP may not be charged for any portion of the cost of the program. The nursing facility must reimburse newly employed CNAs who have personally paid for NATCEP or CEP costs prior to employment in the facility, in accordance with criteria identified in the Nurse Aide Reimbursement section of this appendix. Medicaid in turn reimburses the nursing facility.

Providers may obtain reimbursement from Medicaid for CNA costs. The reimbursement process and necessary forms are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.9.A. Nurse Aide Competency Evaluation Program and Nurse Aide Registry

Nurse aide candidates must pass both a clinical skills test and a knowledge test in order to become certified. Fees for the individual nurse aide to take the tests, and retake each test up to three times, are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

When a nurse aide has successfully passed the CEP, their name is placed on the Michigan Nurse Aide Registry. Fees relating to initial registration and biennial registry renewal are allowable costs for nursing facility reimbursement. For currently employed nurse aides, the nursing facility is responsible for the direct payment of biennial registry renewal fees. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

Information about training requirements, competency evaluation program and registry data is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.9.B. Nursing Facility Reimbursement

Reimbursement to the nursing facility for NATCEP related costs is calculated as an add-on to the routine per diem rate. The Nurse Aide Training and Testing Program Interim Reimbursement Request (MSA-1324) and instructions are available on the MDHHS website. The total NATCEP add-on amount will be adjusted through the annual cost report settlement process. The Medicaid share of the costs is computed based on the ratio of Medicaid resident days to total resident days for all nursing care provided in the

facility during the cost report period. Refer to the Cost Report Reimbursement Settlement section and the Rate Determination section of this appendix for additional information.

The NATCEP cost center on the Medicaid cost report must be used to report the following:

- Costs of conducting a nursing facility based NATCEP.
- Costs of having employees participate in an approved NATCEP outside the nursing facility.
- Costs of employee competency testing by a regional testing facility.

The costs and staffing levels relating to and charged to the NATCEP cost center must not be included in the nursing facility determination of routine nursing care costs.

The determination of allowable NATCEP costs is made in accordance with provisions in the federal Principles of Reimbursement established for the Medicare Program, and cost limitations in Medicaid policy. Training and evaluation program costs claimed for services and supplies furnished to or purchased by the facility from related organizations must adhere to related party allowable cost principles. The cost of such transactions must not exceed the cost of like items or services in an arms-length transaction with a non-related organization, or the actual cost to the related organization, whichever is lower.

The following are not NATCEP costs and must be classified as routine nursing care costs on the cost report:

- Administrative overhead in a facility-based training program.
- Space costs in a facility-based training program.
- Uniform allowance costs.
- Required in-service training.

NATCEP and CEP allowable cost must only include the costs of activities or items that are directly related to providing approved training and the competency evaluation process. The following table contains eligible training and evaluation activities.

Training Staff	Salaries and wages, employee benefits and payroll taxes for conducting training and evaluation activities, including supervised practical training, and direct time devoted to development and preparation for conducting the NATCEP. Payroll costs allowed for NATCEP do not include the cost of time that the training staff devote to routine in-service training activities, general nursing administration or direct patient care, except for supervised practical training. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Consultants	Costs incurred for non-facility staff to assist in developing and conducting the facility's NATCEP.

Student Staff	Salaries and wages, employee benefits and payroll taxes incurred for the time the student is enrolled in the approved training program, i.e., classroom and required supervised practical training. A reasonable time allowance for student employees traveling to and from the off-site training location or competency evaluation, in accordance with a nursing facility's established and documented travel policy, is allowable as NATCEP cost. Payroll costs allowed for NATCEP do not include the cost of staff time for patient care activities that the nurse aide is performing during the period the student is completing the training program. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Program Supplies	Costs of supplies and materials used in conducting an approved NATCEP.
Training Program Transportation	Travel or transportation costs incurred by facility staff in conducting the NATCEP activity, and for transportation or travel reimbursement to student staff for off-site NATCEP or CEP attendance. Refer to the Facility Vehicle and Transportation, Allowable and Non-Allowable Cost section of this appendix for mileage allowance provisions. Use of a facility owned vehicle for staff transportation for training is not charged to NATCEP. Facility vehicle operation cost must be classified as administrative overhead and is considered in the routine per diem rate.
Outside Contracted NATCEP Paid Directly by the Facility	Cost to obtain approved nurse aide training of facility employees by an outside entity approved NATCEP. The nursing facility is responsible to ensure that the contractor is an approved NATCEP.
Outside Contracted NATCEP Costs Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for an approved NATCEP participation and completion prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.
Competency Evaluation Fees Paid Directly by the Facility	Fees paid by the nursing facility to a State-approved competency evaluator. This includes testing and retesting fees, rescheduling fees, and nurse aide registry.
Competency Evaluation Fees Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for State-approved competency evaluation and registration fee prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.
Miscellaneous Costs	Allowable costs that are not specifically identified in another category include, but are not limited to, the following items: ▪ Rental costs for space located out of the facility are allowable only if the space is used solely for the training and competency evaluation program. Space costs not meeting this requirement are reimbursable with the Plant Cost Component of the routine per diem. ▪ Reasonable rental expense for training equipment necessary for conducting an approved training program. ▪ Nurse aide biennial Registry Document renewal fees for current employees.

Equipment Purchased	Equipment purchased and used specifically for the nursing facility based NATCEP are reported as NATCEP cost center costs for Medicaid cost reporting and reimbursement purposes. NATCEP equipment costing less than $5,000 may be expensed in the year of acquisition and reported in the NATCEP cost center. Equipment acquired as part of an integrated system costing greater than $5,000 must be amortized at an annual rate of 15% for each cost reporting year the equipment is used in the NATCEP, up to a maximum of seven years. Instructions for NATCEP equipment reporting are included in the annual cost reporting instructions.

9.9.C. Nurse Aide Reimbursement

A nursing facility must reimburse a newly hired CNA if the CNA paid for nurse aide training, competency evaluation and registry, and completed the approved training program within 12 months prior to employment in that facility. The nursing facility is not required to reimburse the CNA in cases where the expenses were paid by an employment or education training program or were reimbursed by the CNA's previous employer. The nurse aide should not be reimbursed for more than 100 percent of the NATCEP or CEP costs they paid.

The nursing facility is responsible to ensure that a newly hired CNA who requests reimbursement of training and testing expenses has not already received payment for these costs. An aide who paid for any of these eligible costs and received payment of a portion of the expenses from prior facility employment is eligible for only the remaining balance from the new employer.

The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, Certified Nurse Aide Training Reimbursement form (MSA-1326), available in the Forms Appendix and on the MDHHS website. The reimbursement should be requested within the first six months of employment or work as a certified CNA.

NATCEP costs that are eligible for reimbursement to the individual nurse aide include:

- Training program cost including fees for textbooks and required course material up to a maximum of $650. Medicaid will update the maximum allowable reimbursement limit effective October 1, 2006 and biennial thereafter, based on the Global Insight's Skilled Nursing Facility Market Basket Without Capital Index corresponding to that update period. The training program maximum reimbursement amount will be updated biennially on the RARSS website.
- Competency Evaluation Program testing fees, including retesting fees; CEP testing required due to the nurse aide registry document expiration; and rescheduling fees.
- Registry or Registry Renewal Document fees that the CNA personally paid within 24 months prior to being employed in the nursing facility.

For cost reporting and audit purposes, the nursing facility must maintain a copy of the MSA-1326 signed by the employee and documentation reflecting reimbursement to the employee. This documentation must include a copy of a receipt for cash payment, a copy of a cancelled check, or a credit card receipt showing the amount paid by the nurse

aide and the date of payment, as well as copies of the nursing facility's cancelled checks disclosing reimbursement to the employee.

The nursing facility has the option to reimburse the individual via a one-time payment or payment installments. The reimbursement to the individual, regardless of full-time or part-time employee status, must be fully paid within six months of the individual's date of employment, or must be prorated based on their dates of employment in the facility if employed for less than six months. If the nursing facility fails to reimburse a CNA employed in the facility within this timeframe, the unpaid balance will not be an allowable NATCEP or routine nursing care cost. This determination does not relieve the nursing facility of its obligation to reimburse the nurse aide. Wages may not be reduced to offset the facility's obligation to pay the nurse aide for training, competency evaluation, and registry costs.

The nursing facility is not obligated to pay the remaining balance of nurse aide training costs at the time an employee who has worked less than six months leaves facility employment. The CNA has the opportunity to recoup the non-reimbursed costs through subsequent employment at other nursing facilities. The facility should properly record payments so that the unpaid amount is not carried as a payment obligation.

9.9.D. Nursing Facility Lockout and Loss of NATCEP Approval

A provider with a facility-based training CNA program is not eligible for Medicaid reimbursement of training costs when it has been issued a final notice from CMS or the SSA of the withdrawal of NATCEP approval, or of a NAT prohibition (lockout). For Medicaid reimbursement purposes, the lockout effective period coincides with the SSA period notice to the nursing facility. The nursing facility must not claim Medicaid reimbursement for costs associated with any facility-based training class beginning after the withdrawal or lockout effective date identified in the final notice. Nurse aide students beginning training prior to the withdrawal effective date are allowed to complete training, and the related costs to complete that training class are eligible for NATCEP reimbursement. Nurse aide training costs incurred for that facility based program subsequent to completion of that student class are not allowable NATCEP costs. This disallowed cost is also not allowable under routine nursing care cost.

Although the nursing facility experiencing approval withdrawal or lockout status cannot conduct its own training, the nursing facility must provide and reimburse for training and competency evaluation of its new nurse aide employees at approved sites. Such costs are eligible for Medicaid cost reporting and reimbursement in the annual cost report under the appropriate NATCEP cost categories. Nurse aide reimbursement for eligible training and competency evaluation personally paid expenses are allowable to be reported as NATCEP cost in the nursing facility annual cost report.

In the event that the nursing facility has been granted a waiver for a NAT program prohibition or lockout by the SSA, the nursing facility must comply with the provisions of the nursing facility waiver request and the requirements set forth by the SSA in the waiver approval. The facility-based NATCEP operating under a waiver is subject to audit by Medicaid for compliance with these requirements. If the nursing facility fails to conduct the program in accordance with these requirements, the training program

expenses are not allowable costs for NATCEP or routine nursing cost reimbursement by Medicaid.

9.10 Beauty and Barber Service Cost Center

Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets), that residents need are considered routine patient care. The provision of such services is reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility. Personal services provided by a professional beautician or barber are unallowable costs.

If the nursing facility designates an area for providing non-routine personal hygiene services, such as professional manicures, or hair styling, costs must be separately reported and accounted for in the cost report. Direct and overhead costs related to these services must be separately accounted for in this special services cost center and should not be included in the cost of providing routine nursing care.

9.11 Special Dietary Cost Center

Medicaid provides for reimbursement outside the per diem rate to non-profit nursing facilities for the cost of meeting residents' special dietary needs for religious reasons. Nursing facilities requesting reimbursement must report these costs as a separate cost center in the Medicaid annual cost report. Direct costs may include food purchase, salary and wages for the extra staff time for preparation, supplies and kitchen utensils necessary for preparation and service. The costs applicable to plant operations costs related to the special dietary needs will be determined through the Medicaid cost finding process.

9.12 Hospital Leave Days

A separate accounting of costs incurred due to hospital leave days is not necessary.

9.13 Non-Available Beds

In special circumstances, nursing facility beds may be designated "non-available for occupancy" for Medicaid cost reporting when the patient care rooms in which the beds are located are not used for resident care. Beds with a "non-available" designation remain licensed or certified; the designation is for Medicaid cost reporting and reimbursement determinations only. An approved non-available bed plan reduces the total number of beds used for calculating available bed days for the annual cost report period coinciding with the period of the non-available bed plan. Non-available beds must be located in a discrete area and readily identified for statistical cost reporting. During the period the area is designated non-available for patient care, Medicaid does not reimburse for variable and plant costs attributed to the area designated as having non-available beds.

9.13.A. Qualifying Criteria

A non-available bed plan must include all of the licensed beds in a patient care room. The rooms must be a discrete area and primarily consist of a contiguous physical arrangement of rooms. Rooms may not be a random collection of individual rooms or beds located throughout the nursing facility.

Common physical space located adjacent to or within the designated rooms area will normally be included in the designated non-available bed area. Planned use of any common areas within the designated non-available bed area must be disclosed in the written notice to the RARSS.

Rooms with non-available beds may not be used for resident care service regardless of payer source nor can the space be used for any other normally reimbursable purpose.

Resident rooms that are not used for resident care do not qualify for non-available bed designation. Although the rooms may be used for alternative services, the beds located within the room area must continue to be counted as available for resident care. Physical plant area used for alternative use must appropriately be charged to the applicable alternative services cost center if the services activity results in ancillary care services or other revenue services.

The written request must be submitted within 30 calendar days of the date that the provider removes the beds from service.

9.13.B. Written Notice and Request for Plan Approval

The provider must submit a written request for a non-available bed plan to RARSS. The RARSS must receive the request within 30 calendar days of the date that the beds are to be removed from resident care service. Non-available bed plan requests will not be approved on a retroactive basis. (Refer to the Directory Appendix for contact information.)

The written notice from the provider to RARSS must:

- Indicate the date that the beds will be removed from resident care service and the expected duration of the non-available plan.
- Indicate the reason for the request.
- Include a floor plan of the facility that marks the beds to be designated as non-available.

The RARSS will review the request and provide a written response of approval, denial or a request for additional information. If approved, the RARSS will notify the SSA of the non-available bed designated rooms and effective period.

9.13.C. Life of an Approved Plan

Beds must remain non-available for not less than the balance of the provider's fiscal cost reporting year in which the beds are deemed non-available plus the entire following fiscal year. An exception is when the non-available bed plan is effective on the first day of the provider's fiscal year. The cost report year may qualify as the entire period of the non-available bed plan if the cost report period is not less than 12 months.

Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 30 calendar day period, the plan will become effective on the first of the month in which RARSS received the notice if the beds have not been utilized during that month.

The initial period of the non-available bed plan expires upon completion of the minimum required period.

The nursing facility may request up to two extensions of 12 months each following this minimum period. The agreement may be extended on the basis of the provider's fiscal year. A request for extension must be submitted in writing to the RARSS 30 calendar days prior to expiration of the initial plan. The request for a second extension must be submitted to RARSS 30 calendar days prior to expiration of the first extension. The requests must include at least one of the following items:

- The same rooms and bed area.
- A revision to bring some, but not all, of the beds back into service (if applicable).
- A revision to increase the number of non-available beds that includes all of the beds already designated as non-available.
- A change in the room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

Requests for a revision to bring some, but not all, beds back into service must include:

- The same rooms and the same bed area.
- If applicable, the change in room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

The extensions must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests.

Non-available bed plans expiring on or after April 1, 2005 are limited to two 12-month extensions. When a provider's initial or extended non-available bed plan ends, the nursing facility must return the beds to service or decertify the beds from Medicaid participation. Medicaid will not approve a non-available bed plan that substitutes beds elsewhere in the facility for the formerly non-available beds.

The nursing facility will not be eligible to submit a new non-available bed plan for 24 months following the expiration of the previously approved plan.

A provider may only request a grace period after the final extension period if the provider can demonstrate progress to place the non-available beds into resident care service. The request for a grace period must be made to MDHHS Long Term Care Operations 30 calendar days prior to the expiration of the final extension period. (Refer to the Directory Appendix for contact information.) The request for a grace period must be submitted before expiration of the final extension period, and must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests. The request must specify the date that the beds will be available for occupancy and may not exceed 12 months. An example for such action is gradual facility renovation involving periodic non-available beds in a nursing unit and replacement with non-available beds in another unit as renovation plans progress.

Nursing facilities holding a written agreement with an accredited medical school instructing students in providing geriatric care may request consideration for an exception to policy in this subsection (Life of an Approved Plan). Requests must be submitted in writing to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) and should outline the provisions of the agreement, stating that the medical school staff determines admissions into the program and facility. The request must establish an area in the facility that is a distinct unit for the purpose of conducting the educational program, and the area must continue to meet all other non-available bed plan requirements. A copy of the agreement or contract between the facility and the medical school must be provided to RARSS with the exception request. If the agreement or contract undergoes change, a copy of the new terms of agreement must be submitted for approval prior to implementation.

All requests for an exception to policy will include a review of the facility's historical and current survey performance. Criteria regarding survey history (found in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual) are also applicable to this exception request.

The provider must meet all appropriate certification requirements for distinct part units for the remaining Medicaid beds. Additional beds may have to be decertified in order to meet the distinct nursing unit requirements. The nursing facility may request re-certification of these beds for Medicaid participation after a 24-month period. A request to re-certify must meet all current Medicaid certification requirements.

9.13.D. Change of Ownership (CHOW)

The non-available bed plan approval expires with a change of ownership of the nursing facility. If the new owner wishes to continue the non-available bed plan, they must submit a written request to the RARSS within 90 calendar days of the CHOW. A non-available bed plan submitted after the 90-day period will be considered a new request and must satisfy the qualifying criteria and related policy requirements. If the new owner does not request continuation of the existing plan, the beds will be deemed available for occupancy effective with the date of ownership change.

The new owner may apply to extend the plan to coincide with its cost reporting period by following the extension request policy outlined in the Life of an Approved Plan subsection. The nursing facility change of ownership does not relieve the nursing facility from the restrictions for non-available bed designation limitations for plan extensions other than allow for coinciding with the cost report year of the new ownership.

9.13.E. Amending a Plan

The nursing facility may amend an approved non-available beds designation by submitting a written request to the RARSS. (Refer to the Directory Appendix for contact information.) A non-available bed plan may be amended only one time during the life of the non-available bed plan. A request for an amendment must include the same information as an initial request and will be reviewed using the same criteria. A plan amendment increasing the number of non-available beds is subject to the minimum

period requirement and the designation of all the beds must be effective for the period of not less than the balance of the provider's current fiscal cost reporting year in which the beds are deemed non-available plus the following fiscal cost report year.

A nursing facility holding a written agreement with an accredited medical school that instructs students in providing geriatric care may be permitted to amend a non-available plan more than once in the plan's approved period. Requests to amend a plan under these circumstances must adhere to the requirements outlined in the Life of an Approved Plan subsection of this appendix. As noted, all requests will include a review of the facility's historical and current survey performance consistent with the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual.

9.13.F. Penalty for Use of Non-Available Beds

Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the non-available bed agreement. All beds covered by a non-available bed agreement that is negated during the initial period of the plan will be considered available for patient care for the plan's entire initial period.

All beds covered by a non-available bed agreement that is negated during a plan's extension period will be considered available for patient care beginning with the first day of that cost reporting period of the extension.

9.13.G. Returning Beds to Service

All of the beds in the non-available bed plan will be considered returned to service and available for occupancy when the non-available bed plan expires.

In special circumstances, such as a sudden increase in demand due to closure of a nearby facility, non-available beds may be returned to service before the end of the approved plan with prior approval of the RARSS. A nursing facility with an approved non-available beds plan may submit a written request to return beds to nursing care if the individual nursing facility experiences the need for the beds due to the exception circumstances. The request must identify the reason for the need and the specific beds and room designations being made available. RARSS will provide immediate review and response to the nursing facility request.

9.13.H. Plant Cost Certification

A provider with an approved non-available beds plan has the option to submit to a Plant Cost Certification for the cost report fiscal period in which the beds are approved as non-available for occupancy or the termination of the plan. Refer to the Plant Cost Certification Section in this appendix for additional information.

9.13.I. Cost Reporting

The variable and plant costs attributed to the area designated as non-available and the related capital asset cost are not Medicaid reimbursable costs. The non-available rooms and bed numbers must be reported as a Non-Available Beds cost center on the provider's Medicaid cost report.

Each general service cost center must be evaluated separately to determine if the non-available bed area benefits from the service. The nursing facility may charge specific costs to the Non-Available Beds cost center only when the dollar amount is identifiable. Costs that cannot be specifically identified must be apportioned to the non-available beds cost center using the Medicaid cost report allocation methodology. The statistic or measure used for the general services cost center must also be used to allocate costs to the non-available bed cost center.

Example: If square feet are used to allocate costs to the housekeeping activity, the general services cost center, then square feet must also be used to allocate costs to the non-available bed area. The allocation to the non-available bed cost center is zero when the non-available bed area receives no benefit from the general service.

Example: If a wing is designated as non-available and does not receive any housekeeping services, then the allocation to the non-available cost center is zero.

The reduction in available beds is included in the provider's cost report effective for the fiscal period in which the non-available bed plan is approved by the RARSS. For Medicaid reimbursement determination of tenure and allowable average borrowings, the percentage of the total plant asset costs applicable to available beds must equal the percentage of the facility remaining available for resident nursing care.

9.14 Complex Care

Medicaid-approved complex care cases provide an enhanced reimbursement rate to the facility due to the cost and/or complexity of nursing care or special needs of the beneficiary. Separate cost records are not required for identifying these costs. The Program has designated the special care revenue amount equal to cost. Providers with an approved complex care case must adjust the annual Medicaid cost report by removing the dollar amount of the total difference between reimbursement at the complex care rate and the established routine Medicaid rate from the appropriate nursing care costs. The approved complex care rate is identified on the Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) issued to the facility for the specific beneficiary.

9.15 Quality Measure Initiative (QMI) Special Cost Reporting Requirements

The nursing facility QMI provides payments to facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website. For additional information about the QMI, refer to the Nursing Facility Quality Measure Initiative (QMI) subsection of the Rate Determination section of this Appendix.

The Quality Assurance Assessment Program (QAAP) tax levied for the QMI and the payment amount of the QMI are to be reported on the cost report the year they are applicable and in the following manner:

- The QAAP tax assessed during the cost reporting period is to be reported on the "Quality Measure Initiative Assessment" line of the cost report under the Administrative & General cost center.
- The amount of QMI payments in a cost reporting period are to be reported on the "Quality Measure Initiative Payment" line of the cost report under Routine Services Revenue.

The QAAP tax assessed is adjusted from the cost report in accordance with the Quality Assurance Assessment Tax subsection of the Allowable and Non-Allowable Costs section of this Appendix. An adjustment is also made to the cost report to remove the Net QMI Amount. The QMI adjustment may not exceed zero (i.e., the adjustment is either a negative amount or zero), and the adjustment amount is made to "Miscellaneous – Base" in the Medicaid Routine Care Unit #1 and Medicaid Routine Care Unit #2 cost center of the cost report.

Example: Facility A had $150,000 in QMI QAAP tax assessed and $250,000 in QMI payments during their 2019 cost reporting period, so Facility A would apply a -$100,000 adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.

Example: Facility B had $150,000 in QMI QAAP tax assessed and $100,000 in QMI payments during their 2019 cost reporting period, so Facility A would not apply an adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.

SECTION 10 - RATE DETERMINATION

There are six classes of nursing care facilities for which there are specific reimbursement methods. For a definition of the six classes, refer to the Definitions section in this appendix. Providers reimbursed for care using a special reimbursement calculation or method are addressed at the end of this section.

The determination of a nursing facility's class is made by the SSA. If a nursing facility changes ownership or the services it provides such that a change in class is appropriate, the facility will be reimbursed according to the respective facility class to which it has been changed. The effective date of the reimbursement change is the effective date of the SSA's determination. Nursing facility providers other than Class IV are reimbursed under a methodology that pays the lower of the customary charge to the general public or a prospective payment rate determined by Medicaid.

Payment rates described in this section refer to the provider's prospective per resident per diems and are generally set 30 calendar days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the MDHHS budget.)

NOTE: An illustration of the timeline and calculations for per diem rate setting is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If the cost reporting period of the Medicaid routine unit is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months. The cost reporting period may only cover dates the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day.

The reimbursement rate determination process uses a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate is calculated using the filed cost report, if the cost report was acceptable and was filed with Medicaid within five months from the end date of the cost reporting period. If an acceptable cost report was not filed within this period, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year. If the nursing facility did not file within the five month period, or has amended an original cost report subsequent to the five month period, Medicaid will calculate the prospective rate for an effective date for services no later than the beginning of the fourth month (January 1) of the State fiscal year. Nursing facilities that are required to file an amended cost report in order to include home office costs that were not included in the original cost report due to the difference in cost reporting period from the home office are exempt from this provision. The amended cost report, if filed timely following the completion of the home office cost statement, will be considered filed timely if the original cost report had met the five month filing requirement. Refer to the Cost Classification and Cost Finding section of this appendix for home office cost statement and nursing facility amended cost reports.

10.1 RATE DETERMINATION PROCESS

The per diem reimbursement rate for Class I and Class III nursing facility providers is made up of three components: a plant cost component, a variable cost component, and add-ons.

- For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.
- For Class III facilities, the Plant Cost Component is the lesser of the Facility Per Patient Day Plant Cost or the Facility Plant Cost Limit. The Facility Plant Cost Component is the depreciation, interest and lease expenses calculated on a per patient day basis.
- For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Class II facilities, being proprietary nursing facilities for individuals with mental illness or intellectual disability, are reimbursed an all-inclusive prospective payment rate negotiated with the MDHHS State Mental Health Agency on an annual basis. Final reimbursement is a retrospective cost settlement, not to exceed a ceiling limit. The provider may be eligible for a reimbursement efficiency allowance in the final rate if total allowable costs do not exceed the prospectively established ceiling limit.

Class IV facilities, being state-owned and -operated institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (Developmentally Disabled), and non-profit nursing facilities for individuals with intellectual disabilities, are reimbursed allowable costs determined in accordance with Medicare Principles of Reimbursement and are retrospectively cost settled.

Per diem rates for Class V facilities, Ventilator Dependent Care Units, are set prospectively. Services included in the per diem rate are outlined by contract with Medicaid.

Payment rates for Class VI Hospital Swing Beds are set prospectively as a flat per resident day rate determined by Medicaid.

10.2 Retroactive Rate Changes [Change Made 4/1/2025]

A retroactive rate change may be made for facilities that have interim prospective rates based on filed cost reports. Retroactive rate changes may be made for, but are not limited to, the following:

- audit adjustments to a filed cost report that was used for setting an interim rate;
- facilities that filed timely and were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, a plant rate affected by a DEFRA rate limitation for the cost report period, or when an interim rate was incorrectly calculated;
- audit adjustments that are required because of an appeal;
- audit adjustments that are required because of fraud or facility failure to disclose required financial information; and
- **(text deleted per bulletin MMP 24-55)**

The Plant Cost Component of a rate for the nursing facility that experiences a change of ownership will be retroactively adjusted under the Plant Cost Certification process. The DEFRA Reimbursement Limit application will continue to apply to each rate year until a fiscal year retrospective rate change results in zero DEFRA limit. The nursing facility Plant Cost Component will be calculated on a prospective basis for the year following the zero DEFRA limit rate year.

10.3 Plant Cost Component Class I Nursing Facilities

The prospectively established Plant Cost Component for each Class I nursing facility provider is the sum of the facility Net Property Tax/Interest Expense/Lease Component and Return on Current Asset Value Component. The Plant Cost Component is expressed as a per patient day amount.

10.3.A. Net Property Tax/Interest Expense/Lease Component Per Patient Day

The Net Property Tax/Interest Expense/Lease Component per patient day is calculated under the following formula:

Property Tax/Interest Expense/Lease Plant Cost	-	CAV Excess Borrowings Limit	+	DEFRA Reimbursement Limit (not to exceed zero)	=	Net Property Tax/Interest Expense/Lease Plant Cost

Net Property Tax/Interest Expense/Lease Plant Cost	÷	Nursing Facility Resident Days	=	Net Property Tax/Interest Expense/Lease Plant Cost Per Patient Day

10.3.A.1. Property Tax/Interest Expense/Lease Plant Costs

These plant costs consist of allowable costs for real estate and personal property taxes, interest expense, and lease expense defined under the Allowable and Non-Allowable Cost section and the Cost Classification section of this appendix. The aggregate dollar amount for these plant costs is obtained from the nursing facility cost report. The period of the cost report will correspond with the cost basis period identified for the respective State rate year.

10.3.A.2. CAV Excess Borrowings Limit

The CAV excess borrowings limit is unreimbursable interest due to excess borrowings. An example of the calculation is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of allowable interest expense included in the reimbursable plant cost will be reduced if the nursing facility loan balance applicable to the nursing care unit exceeds the facility reimbursement limit. The nursing facility's average allowable borrowing balance cannot exceed the lesser of the "Nursing Facility Current Asset Value" or the "Nursing Facility Capital Asset Value Limit." If the nursing facility borrowing balance exceeds the limit, a reduction is made to the allowable plant cost for the portion of the excess borrowing. The amount of the reduction is based on the ratio of the limit amount to the average borrowings balance times the dollar amount of allowable interest expense. The following formula is applied to calculate the reduction:

Lesser of (NF CAV) or (NF CAV LIMIT)	÷	Facility Average Borrowing Balance	x	Total Allowable Interest Expense	=	Reimbursable Interest

Total Interest Expense	-	Reimbursable Interest Expense	=	CAV Excess Borrowings Limit (N/A if less than zero)

A nursing facility that has undergone a change of ownership and is incurring interest costs relating to the acquisition financing will be subject to a DEFRA Reimbursement Limit disallowance. The DEFRA Reimbursement Limit calculation will determine if the nursing facility acquisition and financing costs exceed the Medicaid allowable reimbursement increase limit. Reductions to the facility total borrowing balance are made to avoid including the borrowings balance in the reimbursable interest, and to avoid including the total allowable interest expense amount in both the DEFRA limit and the CAV excess borrowing limit.

If the nursing facility has a DEFRA Reimbursement Limit due to the nursing facility acquisition, the nursing facility's total average borrowing balance used in the calculation for CAV excess borrowings limit will be reduced by a calculated dollar amount of borrowings corresponding with the DEFRA Reimbursement Limit. The borrowing amount corresponding with the DEFRA Reimbursement Limit is calculated under the following formula:

Dollar Amount of DEFRA Reimbursement Limit	÷	Nursing Facility Total Allowable Interest Expense	x	Nursing Facility Total Borrowing Balance	=	Reduction to NF Average Borrowing Balance

10.3.A.3. DEFRA Reimbursement Limit

Increases in reimbursement for tenure and interest expense subsequent to a sale or resale (after July 18, 1984) are limited under provisions of the Deficit Reduction Act (DEFRA) of 1984 as defined in federal Medicaid law. The Medicaid application of DEFRA provisions is a limit on the dollar amount of plant cost component reimbursement increase to the provider due to the nursing facility change of ownership. An established formula calculation is used to determine the new ownership's eligible increase reimbursement for tenure and interest (DEFRA Application Limit). If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit does not exceed the DEFRA Application Limit, the DEFRA Reimbursement Limit is not applicable. If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit exceeds the DEFRA Application Limit allowable increase, the DEFRA Reimbursement Limit reduction will be made to the allowable plant costs.

The calculation is made as follows:

DEFRA Application Limit **-** Increase in tenure and interest for new ownership prior to DEFRA Limit **=** DEFRA Reimbursement Limit (not applicable if greater than zero)

DEFRA Application Limit is determined as:

[Allowable historical capital asset cost to the asset original owner (excluding land) for assets in the NF at the time of sale **x** 3.33% **+** [Allowable land value to the seller **+** Historical capital asset cost of the asset's original owner for assets in the nursing facility at the time of sale] **-**

[Purchaser down payment **x** Purchase Mortgage interest rate] **-** Allowable interest expense of the seller for the rate period prior to the sale **=** DEFRA Application Limit

For purposes of the DEFRA Reimbursement Limit calculation, allowable acquisition cost is the cost to the original owner of the asset. An example of this calculation is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Increase in tenure and interest for the new ownership prior to DEFRA Limit is determined as:

Purchaser tenure and allowable interest after acquisition **-** Seller tenure and allowable interest in the Medicaid rate prior to the sale **=** Increase in tenure and interest for new ownership prior to DEFRA Limit

The calculation formula is defined for application when using annualized cost data (reflective of 12-month period). Tenure refers to the purchaser's initial ownership year. Allowable interest refers to interest associated with a facility acquisition. If all of the data elements needed in the calculation do not include data for a 12-month period, the data

elements must be adjusted to reflect a period of equal duration to the cost report base period used in determining the "purchaser tenure and allowable interest after the sale."

The DEFRA Reimbursement Limit continues to apply to the new ownership annual Property Tax/Interest Expense/Lease Component rate using the Plant Cost Certification reimbursement settlement procedure until the limit amount is zero.

10.3.B. Return on Current Asset Value (CAV) Component

The Return on Current Asset Value Component is a per resident day amount representing a use allowance on facility assets. The return amount is determined by multiplying the "tenure factor" times a CAV calculated for the nursing facility. A nursing facility's CAV is determined by a formula using historical costs of the nursing facility's capital assets, as identified in the Allowable and Non-Allowable Costs section in this appendix, times the difference between an asset value update factor and an obsolescence factor. Assets purchased prior to 1960 are treated as assets brought into service in 1960. A nursing facility's CAV for rate reimbursement calculation cannot exceed the "current asset value upper limit" and will not be less than the "current asset value floor."

The calculation for the return on current asset value component is:

Lesser of NF CAV or NF CAV Limit	x	Tenure Factor	=	Total NF Return on CAV		
Total NF Return on CAV	÷	NF Resident Days	=	Return on CAV Component Per Resident Days		

10.3.B.1. Asset Value Update Factor

The asset value update factor used to calculate CAV depends on the type of capital asset. Land improvements, buildings, building improvements, and fixed building equipment are updated using a construction cost index for steel frame buildings in the central United States from the fiscal year the asset was brought into service until the most recent period for which cost report data is available for the respective rate year calculation. The asset value update factor is not applied to land and other assets not specifically listed above.

10.3.B.2. Asset Value Obsolescence Factor

The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements, and fixed building equipment have an obsolescence factor of .03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of .10 for each year the asset has been in service up to a maximum of 10 years. The number of years that the asset has been in service is determined by subtracting the year the asset was put into service from the most recent fiscal year for which data is available under the standard rate setting timeframe.

10.3.B.3. Current Asset Value Formula

A nursing facility's CAV is determined by a formula using historical costs of capital assets. The current asset value for each asset is the historical cost of that asset times the difference between its Asset Value Update Factor and its Asset Value Obsolescence Factor. Assets purchased prior to 1960 are recorded as assets brought into service in 1960. Current asset values are updated annually based on the most recent audited or reviewed cost report. A nursing facility's current asset value is the sum of current asset values for the various asset types.

Example: Building assets with historical cost of $100,000 in service for 10 years through the cost report year used in the rate calculation; the update factor for the 10 years is 1.50; the obsolescence factor is .30 (10 years times .03); the amount included in the CAV compilation for the nursing facility for these assets is $120,000 [$100,000 times (1.50 minus .30)].

If the nursing facility Plant Cost Component is calculated based on Plant Cost Certification data, the new capital assets acquired in the current cost report year and the immediate prior cost report year will be included in the nursing facility historical asset costs for compiling the CAV. The update factor for these assets will be 1.0, and the obsolescence factor will be zero.

10.3.B.4. Nursing Facility Current Asset Value

The current asset value calculation process determines the CAV for the entire nursing facility since capital assets are used for all types of service delivery in that facility. Only the portion of the nursing facility assets having a use related to routine nursing resident care are included for reimbursement under the return on current asset value component. The reference to Nursing Facility CAV is defined as the nursing unit portion of the nursing facility's total current asset value applicable to routine nursing care. The apportionment, expressed as a percentage, of a total facility that is applicable to the routine nursing care unit is determined by means of the facility's annual cost report. The SMA cost reporting process apportions the nursing facility asset costs into the appropriate cost centers for reimbursement purposes.

The Nursing Facility CAV is calculated as:

Total CAV for the NF	x	Percentage representing the nursing unit apportionment	=	NF CAV

10.3.B.5. Class I Nursing Facility Current Asset Value Limit Per Bed

The current asset value upper limit is a maximum per bed dollar amount that will be used for calculating the individual Nursing Facility CAV. The per bed value of the upper limit is based on the historical costs of construction and other asset acquisition costs for nursing facilities opened on or after January 1, 1975. The historical costs are updated through

1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using a construction cost index for steel frame buildings. The update index does not apply an obsolescence factor. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost report and the construction index update. The per bed upper limit is effective for the period corresponding to the State rate year.

The current asset value floor is 30 percent of the current asset value upper limit.

Class I nursing facility current asset value limits per bed for each rate year are available on the MDHHS website. Refer to the Directory Appendix for website information.

10.3.B.6. Nursing Facility Current Asset Value Limit

A current asset value limit is determined by the individual nursing facility and is dependent on the number of beds in the Medicaid nursing unit for the period corresponding with the respective rate effective date. The current asset value upper limit is a maximum dollar amount for the individual Nursing Facility CAV that will be used for calculating the return on current asset value. The Nursing Facility CAV Limit is the number of available beds in the nursing unit times the Class Current Asset Value Limit Per Bed.

The current asset value floor limit is a minimum dollar amount for CAV that will be used for calculating the return on current asset value for that nursing facility. The individual Nursing Facility CAV floor is the Nursing Facility CAV Limit times 30 percent.

10.3.B.7. Tenure Factor

The tenure factor is dependent on the nursing facility provider's number of full years of continued Medicaid certification as of the beginning of the Medicaid rate year (i.e., months of continuous Medicaid certification divided by 12 and disregarding fractions). The continuous Medicaid certification is based on the current ownership of the nursing facility.

Continued Medicaid certification is based on the number of full years that have elapsed from the effective date of a provider's initial Medicaid certification to the beginning of the Medicaid rate year. For example, a provider that has been Medicaid certified for 42 continuous months has, for purposes of the tenure factor, been certified for three full years. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table.

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	.0250
2	.0275

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
3	.0300
4	.0325
5	.0350
6	.0375
7	.0400
8	.0425
9	.0450
10	.0475
11	.0500
12 or more	.0525

The rate of return on current asset value is expressed as an annual return rate. Qualification for the total return rate requires that the period included in the nursing facility cost report used as the basis for the facility plant cost rate include twelve calendar months. In cases where the nursing facility cost report does not include twelve calendar months, the following formula is used to calculate the return rate:

Number of calendar days in the cost report period	÷	365	x	Rate of return on CAV (for the respective years of ownership)	=	Return Rate

Example: A nursing facility has seven years of ownership and the cost report period used for plant costs in the rate calculation is for a nine-month period (275 days). The adjusted return rate is .030 (275/365 times .0400).

If a nursing facility is sold or totally replaced (regardless of facility ownership), years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

When licensure has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the tenure schedule would not revert to zero years at the time of the licensure change. The provider's written request must be submitted at the time licensure is changed.

Exception: Where licensure does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original tenure schedule and forego increased reimbursement for interest expense, or to receive

increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the tenure schedule to revert to zero years and a tenure factor of .0250. Should the provider elect to retain the previous tenure schedule, Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators.

10.4 Plant Cost Component Class III Nursing Facilities

The prospectively established plant cost component for each county medical care facility provider and hospital long term care unit provider is the lesser of the allowable per resident day facility plant cost or the per resident day facility plant cost limit. Proprietary providers are permitted to retain, as part of the plant cost component, up to $.50 of the difference between allowable per resident day plant costs and the per resident day plant costs in effect on March 31, 1985 ($5.66 per resident day).

10.4.A. Facility Plant Cost Per Resident Day

The allowable per resident day plant cost is the sum of depreciation expense, interest expense, property taxes, and allowable lease costs divided by total resident days as determined from the provider's cost report. A facility with a change in facility asset costs may qualify for plant cost limit updates.

10.4.B. Facility Plant Cost Limit Per Resident Day

The individual provider facility Plant Cost Limit is dependent upon when facility beds were constructed and brought into service for Medicaid residents. Nursing facilities existing prior to July 1, 1978 were initially assigned the facility Class Plant Cost Limit for new construction as of that date. A nursing facility constructed after that date is initially assigned the facility Class Plant Cost Limit effective in the year facility beds are constructed and brought into service for Medicaid.

A facility's Plant Cost Limit, expressed as per resident day, is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The individual nursing facility Plant Cost Limit is updated for a nursing facility that undergoes a significant change in facility asset costs. The nursing facility must meet the filing requirements and complete the plant cost certification process to qualify for consideration of the update to the individual facility plant cost limit. A plant cost certification filed after the applicable period's cost report will not be accepted for calculation of an updated facility plant cost limit. The provider must meet the qualifying provisions for Plant Cost Certification eligibility, other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit. The non-available bed plan designation criteria does not qualify the nursing facility for an update to the facility plant cost limit. An existing provider with a change of facility class, major addition, renovation or new construction may be eligible for a Plant Cost Limit update to reflect the change in facility asset costs. An existing facility that chooses to become a Medicaid-participating provider may also qualify for an updated plant cost limit.

The updated plant cost limit is applicable to a nursing facility dependent upon the facility's capital asset project. A nursing facility that is a total new construction, a facility that incurs major capital asset renovation and/or addition, a facility newly participating in the Medicaid program, or a facility that experiences a change in facility class are eligible for updated depreciation, interest, finance fees and property tax components for the facility Plant Cost Limit. The update in the limit is based on a compilation of the facility limit prior to the capital asset change and the Class Plant Cost Limit.

The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction, addition or renovation project and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction addition or renovation project, and the allowable asset costs of the new capital asset project, to the combined allowable old and new asset costs of the nursing facility after completion of the capital asset project. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.

Nursing facility providers that incur a capital asset change resulting from a facility sale of assets will use, as a plant cost basis, only those allowable costs identified in the Allowable and Non-Allowable Costs section in this appendix. The individual nursing facility updated Plant Cost Limit after the sale is only eligible for an update for the interest expense component limit to reflect changes in interest rates.

10.4.C. Facility Class Plant Cost Limit Per Resident Day

The Class Plant Cost Limit is the maximum reimbursement rate, expressed as per resident day amount, for a nursing facility's new construction. The Class Plant Cost Limit is applicable to new construction nursing facilities dependent upon when facility beds were constructed and brought into service for Medicaid residents. The Class Plant Cost Limit is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The Class Plant Cost Limit components are updated annually to reflect changes in industry construction cost, interest rates and corresponding effect on financing fees and real estate taxes due to changes in capital costs. The new construction limit is used in determining the individual nursing facility limit in cases where the nursing facility is an entire new construction or an existing nursing facility has completed a significant capital improvement.

The per resident day Class Plant Cost Limit is the amount that would be paid for a recently constructed and prudently financed facility. Calculation of the plant cost limit is based on a survey of nursing facilities constructed between January 1, 1975 and December 31, 1977, and initially updated to June 30, 1978. The original Class Plant Cost limit individual components are updated annually using published economic indicators identified in the subsections addressing the specific component of the limit. The Class Plant Cost Limit annual updates are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

10.4.C.1. Facility Class Plant Cost Limit Depreciation Expense Component

The value for the depreciation expense component is a sum based on the mean of the surveyed values of depreciable assets (referenced above) and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in accordance with Medicare Principles of Reimbursement. The per resident day depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations which have a direct impact on plant costs. The depreciation component is updated using the economic index release as published under U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables for Nonresidential Structures.

10.4.C.2. Facility Class Plant Cost Limit Interest Expense Component

The value for interest expense is based on the surveyed mean of interest rates paid (referenced above) and the mean asset values for facilities constructed during the initial three-year survey period. The per resident day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the interest component limit is updated by applying an index of change in interest rates for home mortgage loans (reflected in conventional new home mortgage rates, as published by the Federal Housing Finance Board for Newly Built Homes) to the interest rate used to calculate the original interest component limit.

A nursing facility that undergoes a change of ownership is eligible for an update to the individual facility Plant Cost Limit. The update will only include an adjustment to the interest component of the individual facility Plant Cost Limit in effect prior to the sale. The adjustment will be made to the interest component of that prior limit to reflect the change in the interest rate index between the period reflected in the prior limit calculation and the date of the facility sale.

10.4.C.3. Facility Class Plant Cost Limit Financing Fees Component

The value for financing fees is based on the mean of financing fees of the surveyed construction (referenced above). The per resident day financing fees component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original financing fees component limit.

10.4.C.4. Facility Class Plant Cost Limit Tax Expense Component

The value for property taxes is based on the mean of property taxes of the surveyed taxable properties (referenced above). The per resident day property tax component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original property tax component limit.

10.5 Variable Cost Component (VCC) – Class I and Class III Facilities

The variable cost component of the nursing facility per resident day rate reflects the Medicaid determination for reimbursement for the nursing facility base and support costs incurred for routine nursing care. Base and support cost classifications are discussed in detail in the Cost Classifications and Cost Finding subsection of this appendix. The calculation of the component uses nursing facility historical costs and economic index application to adjust cost levels to coincide with the State rate year periods. The support costs and total variable (base plus support) costs are separately subjected to rate ceiling reimbursement limits dependent on individual facility bed size and facility class.

For Class I and Class III nursing facility rate setting periods beginning on or after October 1, 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) or the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).

VCC = (lesser of VRB or Class VCL) + EIU

10.5.A. Variable Rate Base (VRB)

The facility Variable Rate Base is the sum of the facility's indexed base cost component and the facility's indexed support cost component. For rate setting purposes, the per resident day amount used for the provider's Variable Rate Base is the lesser of the calculated Variable Rate Base or the Class Variable Cost Limit.

VRB = Base Cost Component + Support Cost Component

10.5.A.1. Base Cost Component (BCC)

A facility's BCC is the facility per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

BCC = (base costs/total number of resident days) X Cost Index

- Facility's base cost per day - the facility base costs divided by the total number of resident days for the cost reporting period.

10.5.A.2. Support Cost Component (SCC)

A facility's support cost component is the facility's BCC multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that nursing facility bed-size group.

SCC = BCC X applicable S/B ratio (Facility or Bed-Size Group Limit)

- Facility's support cost per day - the facility support costs divided by the total number of resident days for the cost reporting period.
- Facility Support-to-Base Ratio (S/B-Facility) - the nursing facility's allowable support costs divided by the allowable base costs for the cost reporting period. The individual provider's S/B ratio for rate calculation is limited to the Support-to-Base Ratio Bed Size Group Limit for the provider's bed-size group. The individual nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the

Aged beds, or any other type of licensed beds where nursing care is provided. The provider's S/B ratio is rebased annually from the most recent audited cost period, regardless of ownership.

- Support-to-Base Ratio – Bed Size Group Limit (S/B-Group) – the 80th percentile of the support-to-base ratios for nursing facilities in the same bed-size group for a cost reporting year. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the nursing facility. The nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The 80th percentile is determined by rank ordering the provider nursing facilities within the same bed-size group from the lowest to highest S/B ratio, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid days occurs.

10.5.B. Cost Index (CI)

A facility cost index is the Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated.

Example: Cost report data used to set reimbursement rates for the October 1, 2018 to September 30, 2019 rate year will be indexed to October 1, 2017.

10.5.C. Class Average Variable Costs (AVC) [Change made 4/1/2025]

The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation. **(text deleted per bulletin MMP 24-55)**

AVC = (total Indexed Variable Costs for all NF's in the class)/
(total resident days for all NF's in the class)

- Facility's Variable Costs (VC) - the total allowable base and support costs for a facility to provide routine nursing care services to residents, as determined in accordance with Medicaid allowable costs and reporting requirements.
- Indexed Variable Costs (IVC) – the facility's total VC indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The AVC for October 1, 2018, which is used for the rate year October 1, 2018 to September 30, 2019, is based on variable costs reported in cost reports ending in calendar year 2017 indexed to October 1, 2017.

10.5.D. Class Variable Cost Limit (VCL)

The Variable Cost Limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) per resident day for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC per resident day, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for the facility class of providers is reached. The VCL for the class of providers equals the IVC per resident day of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

- Facility's Variable Cost per resident day (VC/pd) - the facility VC divided by the total number of resident days for the cost reporting period.
- Indexed Variable Costs Per Resident Day (IVC/pd) – the facility's VC/pd indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The VCL for October 1, 2018, which is used for the rate year October 1, 2018 to September 30, 2019, is based on variable costs per resident day reported in cost reports ending in calendar year 2017 indexed to October 1, 2017.

(Subsection 10.5.D.1. Class I Nursing Facility VCL Exception - New Provider Rate Relief was deleted per bulletin MMP 24-55)

10.5.D.1. Class III Nursing Facility VCL Exception – New Hospital Long Term Care Units After July 1, 1990 [Re-numbered 4/1/2025]

Class III nursing facilities that are new long term care units of a hospital, and have a Certificate of Need (CON) approval from the Michigan Department of Health and Human Services (MDHHS) [formerly Michigan Department of Community Health (MDCH) and Michigan Department of Public Health] dated on or after July 1, 1990, are reimbursed according to the method for Class III facilities except that the facility Variable Cost Component is determined as the lesser of the facility Variable Rate Base or the Class I Variable Cost Limit (VCL).

10.5.E. Economic Inflationary Update (EIU)

The economic inflationary update for a facility is the Economic Inflation Rate (EIR) for the class applied to the lesser of the Variable Rate Base or the Class Variable Cost Limit.

EIU = EIR X (lesser of VRB or Class VCL)

Economic Inflation Rate (EIR) - the State legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units

The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively by Medicaid as an individual nursing unit rate per resident day and is based on actual occupancy.

Reimbursement is made for prior authorized ventilator-dependent services/care for residents who have been transferred to a Medicaid contracted facility. The prospective rate covers all ventilator care requirements of the residents, including all the costs of benefits associated with Medicare Parts A and B while the resident resides in the special nursing facility. This includes, but is not limited to, all routine, ancillary, physician, and other services.

Factors used in the determination of the per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years (24 months) of Medicaid operations (from the date of admitting the first Medicaid beneficiary) based upon the statewide average VDC unit reimbursement rate for the current year. The reimbursement rate period beginning on the October 1 after the initial two years of Medicaid operations will utilize the most recent Medicaid cost report ending in the prior calendar year. If this cost report covers a period that is less than seven months or there was no cost report filed in the prior calendar year, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.

10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)

The QAAP was implemented by Medicaid in compliance with Michigan and Federal law. The QAAP provides a QAS payment and Quality Measure Initiative payment to nursing facilities by incorporating funds from the quality assurance assessment tax. When a provider sells a nursing facility, the provider is responsible for all QAAP assessments billed and incurred prior to the date of the sale. The purchaser(s) must assure escrow of any outstanding QAAP amounts owed, or the purchaser(s) becomes responsible for payment of the QAAP and penalty amounts owed before Medicaid participation is granted. If the provider quits the business, the provider is responsible for all QAAP assessments billed and prorated as of the date MDHHS determines the facility closed. The QAAP applies to Class I, Class III and Class V nursing facilities.

10.7.A. Quality Assurance Supplement (QAS) for Class I and Class III Nursing Facilities

The nursing facility will receive a QAS payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied by the facility's QAS per resident day. The facility's historical Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility. A nursing facility that is experiencing a significant increase or decrease in its Medicaid utilization for the current rate year resulting in a difference of greater than five

percent in the nursing facility's total QAS payments for the year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment. Current year Medicaid resident census data must be provided to MDHHS to document the change in order to revise the monthly QAS payment amounts. It is the desired intent of MDHHS to assure accuracy of total QAS monthly payments and to approximate the annual reimbursement due the facility. MDHHS reserves the right to adjust the individual nursing facility monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

A facility's QAS is equal to the lesser of the facility's Variable Rate Base or Class Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDHHS, except for Class III publicly owned facilities, in which the QAAF is multiplied by the lesser of the facility's Variable Cost Component or the Class I Variable Cost Limit. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed to audited cost report data, and to adjust the increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by the quality assurance assessment tax as well as the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment fee may not exceed 6 percent of total industry revenue for the fiscal year.

QAS payments to Class I, III and V providers will be reduced by the amount of restricted funding revenue written off during the current fiscal year. This reduction will be allocated across Class I, III and V providers participating in the QAAP program that receive QAS payments. QAS payments will be reduced by both the state and federal share of the uncollected restricted revenue. Any restricted revenue that is subsequently collected after being included in a QAS reduction will be restored to providers. The QAS reduction will be equal to the total QAAP shortage divided by the total number of Medicaid days used in the QAS payment calculation multiplied by the number of Medicaid days in each facility.

It is the intent of MDHHS that nursing facilities that provide hospice care for residents by contracting with a hospice provider also benefit from this quality program. Medicaid will reimburse hospice providers 100 percent of a nursing facility's QAS rate add-on for Medicaid beneficiaries provided hospice care in Medicaid participating nursing facilities. It is the responsibility of the hospice provider to pay the room and board rate to the nursing facility as specified in their contract for services.

10.7.B. Quality Assurance Supplement (QAS) for Class V Nursing Facilities - Ventilator Dependent Care (VDC) Units

Qualifying VDC units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on one-twelfth of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's QAS per resident day basis. The unit's Medicaid utilization will include all days billed to Medicaid by the VDC unit. A nursing unit that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a

difference of greater than five percent in the nursing unit's total QAS payments for the year must contact MDHHS for consideration of adjustment to the unit's monthly QAS payment. Current year Medicaid resident census data must be provided to the SMA to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDHHS to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the VDC unit. MDHHS reserves the right to adjust the individual VDC unit monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

The VDC unit QAS is equal to the Class I Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDHHS. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment tax may not exceed six (6) percent of total industry revenue for the fiscal year.

10.7.C. Annual Reconciliation

The reconciliation of approved Medicaid days, changes to the variable rate from filed to audited cost report data, and QAS payments is completed on an annual basis within 90 calendar days after the end of the State's fiscal year. For State Fiscal Year 2022, this reconciliation will take place at least 365 days after the end of the fiscal year.

The Reimbursement and Rate Setting Section (RARSS) will reconcile the QAS payments to the provider against the provider's approved Medicaid days and filed and audited cost report data. If RARSS determines that an underpayment has been made, the provider will receive a gross adjustment payment. If RARSS determines that an overpayment has been made, recovery will be made by gross adjustment recovery against future payments. The gross adjustment process follows the Initial Settlement and Final Settlement practices described in the Cost Report Reimbursement Settlements section of this chapter. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must include a written justification of the need for extended payment.

The provider will be given advance notice of the actions taken on QAS payments and has 30 calendar days from the date of the advance notice to request a review of the determination with RARSS. The provider's request for a review must cite specific concerns with the determination.

10.7.D. Nursing Facility Quality Measure Initiative (QMI)

Eligible nursing facilities may receive a supplemental QMI payment. Payments to individual nursing facilities will be determined by their average 5-star quality measure rating on the CMS Nursing Home Compare (NHC) website, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data as described in this

section. In cases of a change of ownership, the new owner's QMI payment will continue to be calculated based off the prior owner's average quality measure rating, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data.

The average 5-star quality measure rating will be based upon the average rating from July of the prior calendar year to June of the current calendar year (e.g., for the rate year beginning October 1, 2018, the average 5-star quality measure rating would be based on the average rating between July 1, 2017 to June 30, 2018).

For special cost reporting requirements related to the QMI, refer to the Quality Measure Initiative (QMI) Special Cost Reporting Requirements subsection of the Cost Classifications and Cost Finding section of this Appendix.

Refer to the Nursing Facility Resources section of the Directory Appendix for NHC website information, and for additional QMI resources and contact information.

10.7.D.1. ELIGIBILITY FOR QMI PAYMENT

To be eligible to receive a QMI payment, a provider must meet the following conditions:

- The provider must be a Class I or III nursing facility.
- The provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC website.
- The provider must be a Medicaid-certified nursing facility.
- The provider must not be closed for business. That includes a voluntary closure, or an action by MDHHS, CMS or LARA to decertify or delicense a provider.
- The provider must not be designated as a Special Focus Facility (SFF) by CMS. (Refer to the Directory Appendix for SFF list website information.)
- If the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Long Term Care Policy Section as described in the QMI Action Plan subsection.
- The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period. QMI payments made to a provider found to have no days of Medicaid nursing facility services during the state fiscal year shall be recouped by the Michigan Department of Health and Human Services (MDHHS).

MDHHS will generally check in August prior to the beginning of a rate year and approximately every three months thereafter to see which facilities are designated as SFFs or have closed. A provider designated as a SFF will not be eligible to receive any QMI payments until they graduate from the SFF list. A SFF that graduates after the rate year begins will only be eligible for prorated QMI payments for the balance of the remaining months of the rate year (e.g., a provider that graduates from the SFF list would not receive reimbursement equal to what they would have received had they been eligible for the entire rate year). If a provider has closed or graduated from the SFF list,

MDHHS may recalculate some or all QMI payments depending on the amount of available funds.

10.7.D.2. QMI Action Plan

A provider with an average quality measure rating below 2.5 stars must file an acceptable QMI action plan with the Long Term Care Policy Section to be eligible for a QMI payment. The action plan will need to provide specific details reflecting how a provider intends to use QMI funds to increase quality outcomes. The Long Term Care Policy Section will electronically provide written notice to providers with a rating below 2.5 stars and will provide the expectations for the action plan. A plan that does not provide the specific details required in the notice will not be accepted by the Long Term Care Policy Section.

The Long Term Care Policy Section will set a due date in the notice for a provider to submit the action plan. A provider that fails to submit an action plan by the due date cannot receive payment until an action plan is sent to and accepted by the Long Term Care Policy Section. If a provider fails to submit an acceptable action plan within 30 days of the due date, they will be unable to receive a QMI payment for the remainder of the fiscal year. Unless directed otherwise by the Long Term Care Policy Section, the action plan must be sent electronically as specified in the notice.

10.7.D.3. QMI Payment Methodology

The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a period of at least seven months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). For the purposes of this section, a cost report refers to the uniform Medicaid nursing facility cost report or a less than complete cost report. The sum of the total Title XIX patient days in the Medicaid Routine Care Unit #1, Medicaid Routine Care Unit #2, and the Medicaid Special Care Unit #1 over the sum of the total inpatient days in all nursing facility units on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1, Medicaid Routine Care Unit #2, and the Medicaid Special Care Unit #1 is 1,000, while the sum of total inpatient days in all units is 1,500, the Medicaid utilization rate would be 66.7%). If the immediate prior year-end cost report does not cover a period of at least seven months, then the Medicaid utilization rate will be determined as follows:

- If the prior year-end cost report covers a period of less than seven months, and if multiple cost reports were filed by the current or prior facility owner, then all cost reports submitted for the prior year-end will be used in calculating the Medicaid utilization rate (i.e., if the current owner and the prior owner each submitted a 2016 year-end cost report, then both cost reports would be used to determine the Medicaid utilization rate).
- If no cost report was filed for the prior year-end because the current or prior owner submitted an extended period cost report, then the most recent cost report filed prior to the previous calendar year that covers a period of at least seven months will be used in calculating the Medicaid utilization rate.

- If the immediate prior year-end cost report is the only cost report the provider has ever filed, then that cost report will be used in calculating the Medicaid utilization rate even if it covers a cost reporting period of less than seven months.
- A provider that has not filed an immediate prior year-end cost report will be assumed to have no Medicaid utilization.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale will be applied as follows:

- For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid utilization rate.

Example: Facility A has a Medicaid utilization rate of 64% while Facility B has a Medicaid utilization rate of 35%, so Facility A would receive 100% of their QMI payment while Facility B would receive 35% of their payment.

Effective for rate years beginning on or after October 1, 2018, an adjustment is made for the submission of resident satisfaction survey data from recently performed surveys. The Long Term Care Policy Section will provide notice to facilities prior to the fiscal year on how to submit the data, what documentation is necessary, and where to submit resident satisfaction survey data by a due date specified in the notice. Per-bed QMI payments will be multiplied by 100% for facilities that submit acceptable resident satisfaction survey data and documentation, but payments will be multiplied by a percentage set by MDHHS for facilities that do not submit the data and documentation. The resident satisfaction survey must have been conducted no more than 12 months before the submission of the notice, and survey data submitted for prior year QMI payments will not be accepted.

The following formula demonstrates the monthly adjusted QMI payment (for rate years prior to October 1, 2018, the resident satisfaction survey factor is not included in the formula):

- QMI Gross Adjustment = (([NHC Per-Bed Amount] x [Medicaid Utilization Scale] x [Resident Satisfaction Survey Factor]) x [Number of Licensed Nursing Facility Beds])/[Number of Eligible Payment Months]

Examples:

- For rate year October 1, 2017, Nursing Facility A has an average NHC rating of 5 stars, a Medicaid utilization rate of 55%, 100 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 5-star rating is $2,000, so the QMI Gross Adjustment = (($2,000) x (75%) x (100))/12 = $12,500/month.

- For rate year October 1, 2017, Nursing Facility B has an average NHC rating of 2 stars, a Medicaid utilization rate of 32%, 45 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 2-star rating is $1,250, so the QMI Gross Adjustment = (($1,250) x (32%) x (45))/12 = $1,500/month.
- For rate year October 1, 2018, Nursing Facility C has an average NHC rating of 3 stars, a Medicaid utilization rate of 78%, 200 licensed nursing facility beds, has not submitted resident satisfaction survey data, and meets all the payment eligibility requirements. The NHC per-bed amount for a 4-star rating is $1,750 and the resident satisfaction survey factor for facilities with no survey is 85%, so the QMI Gross Adjustment = (($1,750) x (100%) x (85%) x (200))/12 = $24,791.67/month.

All values in the examples above are for example purposes only and do not reflect actual rates.

10.8 Class II Nursing Facilities – Proprietary Nursing Facility for Individuals with Mental Illness or Intellectual Disabilities

The Class II proprietary nursing facilities for individuals with mental illness or intellectual disabilities are reimbursed an all-inclusive prospective payment rate negotiated with the MDHHS State Mental Health Agency on an annual basis. Rate ceiling limits are prospectively set for allowable costs and resident occupancy for determining final reimbursement for the annual services. Final reimbursement is retrospective cost settlement, not to exceed the ceiling limit. Nursing facility allowable costs included for reimbursement are determined in accordance with Medicaid cost reporting requirements and allowable and non-allowable cost policies, including plant cost based on allowable depreciation expense. The provider is paid a reimbursement efficiency allowance equal to the lesser of $2.50 per resident day or the difference between the prospective ceiling limit and the nursing facility actual allowable cost.

10.9 Class IV Nursing Facilities – Institutions for Individuals with Developmental Disabilities

State-owned and -operated institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and non-profit nursing facilities for individuals with intellectual disabilities are retrospectively cost settled.

The State Mental Health Agency must submit rate information regarding the facility's expected costs for the prospective year in an Interim Rate Request letter to Medicaid at the beginning of the Medicaid rate year. Subsequent requests may be submitted during the rate year if rate adjustments are necessary. The reimbursement rate for the new Medicaid rate year will not be updated until the State Mental Health Agency submits the Interim Rate Request letter.

The provider is reimbursed an interim per diem rate based on the cost information submitted. The interim reimbursement is adjusted to actual allowable costs through annual cost settlement. Refer to the Cost Reporting and the Rate Setting sections of this appendix for additional information.

10.10 Class VI Nursing Facilities – Hospital Swing Beds

The reimbursement rate for hospital Swing Beds (Class VI) is set prospectively as a flat per diem rate determined by Medicaid. Swing bed reimbursement occurs after the combined length of stay in an acute care bed and a swing bed exceeds the average length of stay for the Medicaid diagnosis related group (DRG) for the admission.

The rate is the weighted statewide average per diem rate paid for routine nursing care. The rate calculation sums Medicaid per diem payments and divides the sum by the number of Medicaid service days paid to Class I and Class III facilities as reflected on the State's prior fiscal year's Medicaid report of services and payments.

10.11 Class VII Nursing Facilities – State Veterans' Homes

Reimbursement rates to State Veterans' Homes will be prospective, per patient day, and based on the PDM classification of each resident. MDHHS will utilize the PDM classifications used under the Medicare skilled nursing facility (SNF) prospective payment system (PPS) as calculated by the MDS 3.0. PDPM consists of four case-mix categories and six rate components. The PT and OT component, the SLP component, the NTA component and the Nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component. The Variable Per Diem adjustment and the add-on payment for residents with AIDS under the Medicare SNF PPS are not included in this rate methodology.

The formula for PDPM payments is as follows:

PDPM rate = PT rate + OT rate + SLP rate + NTA rate + Nursing rate + Non-Case-Mix rate

Refer to the Directory Appendix for website information regarding PDPM.

The rate associated with an individual PDPM component will be set as a percentage of the rate paid by the Medicare SNF PPS. The percentage used to set rates will not exceed 100% of the corresponding Medicare PPS rate. MDHHS will notify the State Veterans' Homes of the percentage and specific payment rates by October 1 of each year.

The PDPM categories used for payments will be based on the applicable MDS assessment(s) to the billing period. Example: Services were rendered from April 1 through April 30, and MDS assessments were conducted on January 15 and April 15. The payment to the provider would be based on the January 15 assessment for dates of services from April 1 through April 14, and would be based on the April 15 assessment for dates of services April 15 through April 30.

State Veterans' Homes are excluded from the reimbursement policy that requires Medicaid to pay the lower of the customary charge to the general public or the prospective rate determined by Medicaid.

In conformance with the Veterans' Health Programs Improvement Act of 2004, per diem payments received by State Veterans' Homes from the federal Department of Veterans Affairs will not be considered a third-party liability or otherwise used to directly reduce Medicaid payments to these providers.

State Veterans' Homes are excluded from the NF QAAP and all supplemental payments funded by the QAAP.

State Veterans' Homes will receive payment for services through gross adjustments.

10.12 Add-Ons

Add-ons are items that provide reimbursement to a provider for costs that are not previously included in the provider's variable cost component.

10.12.A. Special Dietary

The Coverages portion of this chapter, Dietary Services and Food subsection, provides for program reimbursement to non-profit nursing facilities for special dietary needs for religious reasons. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total special dietary add-on reimbursement to the nursing facility during the reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

A qualifying nursing facility that has previous year cost history of special dietary costs will have the interim payment rate add-on based on special dietary cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate will be the source of the cost data for the current interim rate add-on.

A qualifying nursing facility that does not have previous year cost history of special dietary costs will have an interim reimbursement rate add-on based on estimated cost data. The nursing facility must submit a written request identifying the estimated costs to be incurred in food purchase and preparation associated with special dietary needs for religious reasons. The request must be submitted to the RARSS and must include a certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix for contact information.) The written request must present the following data for the current cost report year:

- Estimated resident days (not less than 85% occupancy rate for all nursing facility resident units)
- Estimated raw food purchase costs, including a detailed listing of the types of food to be purchased for special dietary needs for religious reasons.
- Estimated cost for supplies, tableware, cooking utensils, etc. for food preparation and service associated with special dietary needs for religious reasons.

The submitted data will be subject to review and adjustment by Medicaid for consideration and calculation of the interim rate and the add-on reimbursement rate to the facility. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.12.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-on

Certification, Survey & Enforcement Appendix, Staff Certification section provides for nursing facility Medicaid reimbursement for Medicaid's share of costs incurred by the nursing facility for approved Nursing Aide Training and Competency Evaluation Program (NATCEP) expenditures. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total NATCEP add-on reimbursement paid to the nursing facility during the nursing facility's cost report reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Classifications and Cost Finding section and Cost Report Reimbursement Settlement section of this appendix for additional information.

The interim rate add-on amount is limited to a maximum per diem of $1.00 per resident day; however, the nursing facility cost reimbursement settlement for these training costs is not subject to a per diem limit. The interim payment rate add-on will reflect the nursing facility's prior year cost history of NATCEP costs utilizing the NATCEP cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate is the source of the cost data for the current interim rate add-on, except where a more recent interim reimbursement request has been submitted by the nursing facility.

A nursing facility that is notified by the SSA of loss of NATCEP or CEP, has been placed on NATCEP lockout status, or has a NATCEP withdrawal of program approval will be notified by Medicaid that its interim reimbursement NATCEP add-on amount will be deleted from the reimbursement rate. The nursing facility must submit a completed interim reimbursement request identifying expected NATCEP allowable costs, in accordance with policy provisions referenced above, for consideration of an interim reimbursement add-on amount for allowable NATCEP costs incurred during the lockout period.

A nursing facility is eligible to submit an interim reimbursement request for a change in the interim payment rate add-on amount in the following situations:

- The nursing facility is experiencing a change in its current year NATCEP cost level that would cause a per diem increase or decrease in excess of $.25 per day in the current period reimbursement rate add-on.
- The nursing facility does not have previous year cost history of NATCEP cost.
- The nursing facility has been identified a lockout facility for NATCEP or CEP, or has loss of approval of its NATCEP, and has made acceptable arrangements for securing approved nurse aide training for nursing facility staff.

The nursing facility must submit a completed Nurse Aide Training and Testing Program Interim Reimbursement Request (form MSA-1324) identifying the estimated costs to be incurred in providing approved NATCEP training for the nursing facility staff and projected resident census data. The request must be submitted to RARSS and must include the signed certification statement attesting to the accuracy of the data and

signed by the nursing facility authorized representative. (Refer to the Directory Appendix for contact information.) Electronic copies of the request form and completion instructions can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

The submitted data is subject to review and adjustment by Medicaid for consideration and calculation of the interim rate add-on payment to the facility. Medicaid will issue the provider a rate notice indicating the accepted cost level for interim rate determination, or a request denial and reason for such action. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.13 Special Circumstances – Rate Determination

10.13.A. New Facility and Provider

A new facility is a provider operating a nursing facility where there is not Medicaid historical cost. Examples include:

- A newly constructed (non-replacement) facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different provider class.
- An existing nursing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past two years (24 months).

10.13.A.1. New Provider Nursing Facility Per Resident Day Plant Cost

A new provider in the Medicaid program is eligible for the Plant Cost Certification process to reflect the facility asset costs and related plant costs. The Plant Cost Certification data submission will be used for calculation of the nursing facility Plant Cost Component as outlined in the policy for the respective nursing facility class. Refer to the Plant Cost Certification section of this appendix for additional information.

10.13.A.2. New Provider Nursing Facility Variable Cost Component

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. The first two cost reporting periods must cover a period of at least 19 months (the first cost reporting period must cover a period of at least seven months, and the second cost reporting period must cover a period of 12 months) and the facility must have averaged six or more Medicaid residents per day. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in the Rate Determination section of this appendix.

A new provider that purchases an existing facility participating in the Medicaid program or a provider with an existing, participating facility that makes major additions, renovations, or new construction does not qualify for these special methods because there are historical variable costs on which to base rates. The Variable Rate Base will be determined in accordance with Medicaid policy identified in applicable subsections of this appendix.

This section does not apply to Class V providers.

10.13.B. Complex Care

The Nursing Facility Coverages chapter of this manual details Medicaid policy on complex care cases. Complex care cases are those requiring specialized care beyond services covered by the usual Medicaid per diem rate. The payment rate for specially-placed residents is a negotiated prospective rate per resident day.

Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved nursing facility. The negotiated rate provides reimbursement adequate to meet the unusual needs of this type of resident in a less costly and more appropriate environment than an acute care hospital setting.

Factors used in Medicaid's negotiation of the per resident day prospective rate include, but are not limited to, complexity, type of equipment and supplies required, the resident's condition, and the marketplace availability of placement. Any authorized increase in the per diem rate represents only the cost of the service. The negotiated prospective rate is re-evaluated, in consideration of the resident's needs, prior to the last day of the approval period.

10.13.C. Hospital Leave Days

The Hospital Leave Days Section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

Reimbursement for a hospital leave day is a single rate paid to all nursing facility providers regardless of facility class. The rate is determined annually with an effective period coinciding with the State fiscal year. The rate determination utilizes the Class I nursing facility Class Average Variable Cost (AVC) for the State fiscal year. The hospital leave day reimbursement rate represents a calculated salary and wage component of the room and board cost portion of the total AVC. The room and board portion is equal to 95 percent of the Class I nursing facility AVC, and the salary and wage component is determined as 66 percent of the room and board cost. The formula for calculating the hospital leave day rate is:

AVC (Class I NF)	**x**	95% (room and board portion)	**x**	66% (salary and wage component)	**=**	Hospital Leave Day Rate

Hospital Leave Day rate information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

10.13.D. Therapeutic Leave Day

The Therapeutic Leave Days section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for a therapeutic leave day is the nursing facility's established per diem rate in effect for the period coinciding with the leave day.

10.13.E. One-Day Stay

The One-Day Stay section of the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for an approved one-day stay is the nursing facility's established per diem rate in effect for the period coinciding with the stay.

10.13.F. Facility Innovative Design Supplemental (FIDS) Program

Effective for dates of service on and after October 1, 2007, Medicaid providers participating in the Facility Innovative Design Supplemental (FIDS) program are eligible to receive supplemental reimbursement for room and board services provided to Medicaid beneficiaries when the beneficiary resides in a FIDS bed. FIDS participating facilities are eligible for the reimbursement supplement for up to 20 consecutive years beginning in the fiscal year of the project completion date. For projects completed on or after January 1, 2008, providers must plant cost certify or forgo the FIDS reimbursement supplement.

The FIDS facility standards and required culture change must be maintained throughout the Medicaid supplemental payment program. FIDS participating facilities will be reviewed annually by BPHASA to certify continued participation in the culture change. Reimbursement of the FIDS payment will be terminated if it is determined that a facility is not compliant with the culture change requirement. FIDS participating nursing facilities receive increased capital reimbursement for FIDS construction and renovation projects. The increased reimbursement is paid through the claims reimbursement process. Reimbursement of the supplement amount is contingent upon sufficient appropriation to the Medicaid budget.

10.13.F.1. Change of Ownership

A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially decides to discontinue

participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify the LARA, Bureau of Community and Health Systems (BCHS) team manager and BPHASA. MDHHS will notify the provider of the supplemental payment amount upon reinstatement of participation in FIDS. MDHHS will notify the provider of the terminated supplemental payment if the facility is determined ineligible for the supplemental payment because the new owner has discontinued or plans to discontinue the FIDS facility standards or culture change.

10.13.F.2. FIDS Program Reimbursement Methodology

FIDS participating facilities that have received approval from LARA for construction or renovation design plans that complied with quality goals of the FIDS program to improve nursing facility quality of life and nursing facility structures are eligible for reimbursement. If a provider chooses to discontinue participation in the design and/or culture change aspects of the FIDS program, the provider must contact the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) 30 days prior to the discontinuance. (Refer to the Directory Appendix for contact information.) The FIDS reimbursement supplement will be discontinued when the facility no longer participates in the design and/or culture change.

MDHHS confirmation and approval that a FIDS participating facility has completed the pre-approved construction or renovation project(s) allows the facility to be eligible for the capital reimbursement supplement. The reimbursement supplement only applies to qualifying FIDS costs above the nursing facility's Capital Asset Value (CAV) Limit for Class I and the Plant Cost Limit (PCL) for Class III. Qualifying costs are the cost of capital assets such as land, land improvement, building, building improvement, and equipment that meet the MDHHS capital asset classification. Providers submitting for plant cost certification can identify all costs for certification but must distinguish FIDS qualifying costs on the certification request. As FIDS qualifying costs fall below the nursing facility's CAV or the nursing facility's PCL, the supplement amount is adjusted. The reimbursement supplement reflects qualifying costs prorated over 20 consecutive years. Medicaid reimbursement methodology for the FIDS program follows current MDHHS nursing facility cost-based principles and rate determination guidelines and policy, including plant cost certification, except as identified below for Class I and Class III providers.

10.13.F.3. Class I Nursing Facility Reimbursement for FIDS

For Class I nursing facilities participating in the FIDS program, the supplement amount, up to five dollars ($5) per Medicaid day, is added to the Return on Current Asset Value Component (RCAV) for qualifying FIDS construction or renovation project costs above the nursing facility's CAV Limit. Medicaid reimbursement methodology for the FIDS program follows current Medicaid nursing facility reimbursement guidelines and policy with the exceptions noted below:

- Up to five dollars ($5) per Medicaid day is added to the nursing facility's RCAV.
- The supplement amount is based on qualifying costs above the nursing facility's CAV Limit determined by MDHHS either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to

an adjustment following the completion of an audit to the applicable period's cost report in which the FIDS project is initially reported.

- To determine the amount of the FIDS supplement, MDHHS will utilize the following calculation:
  - Qualifying FIDS construction or renovation costs above the CAV Limit are divided by the number of FIDS beds in the project divided by the number of years remaining in the supplemental program divided by 365 days.

10.13.F.4. Class III Nursing Facility Reimbursement for FIDS

For Class III nursing facilities participating in the FIDS program, MDHHS will increase the Plant Cost Component (PCC) up to five dollars ($5) per Medicaid day for FIDS construction of renovation project costs above the nursing facility's PCL. MDHHS reimbursement methodology for the FIDS program follows current MDHHS nursing facility reimbursement guidelines and policy with the exceptions noted below.

- Up to five dollars ($5) per Medicaid day is added to the nursing facility's PCC.
- The supplement amount is based on qualifying costs above the re-determined PCL determined by MDHHS either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to an adjustment following the completion of an audit to the applicable period's cost report in which the FIDS project is initially reported.
- To determine the amount of the FIDS supplement, MDHHS will apply the following to qualifying project costs:
  - For FIDS renovation projects, the supplement is determined using qualifying costs to calculate the plant cost per resident day above the facility's PCL per resident day.
  - For a newly constructed facility, the calculation will be based on plant cost per resident day above the Class PCL per resident day effective the quarter the new construction is placed into service.

10.13.F.5. FIDS Program Billing and Reimbursement Process

Participating FIDS providers are reimbursed per Medicaid day when claims are submitted for services provided in the FIDS area. FIDS facilities compliant with facility standards and culture change are eligible for the supplemental payment. Only participating FIDS providers billing for room and board in a FIDS area are to use the following revenue codes:

- For a single occupancy/private room, bill revenue code 0119
- For a double occupancy/semi-private room, bill revenue code 0129
- For Therapeutic Leave Day claims, bill revenue code 0189
- For hospice room and board, bill revenue code 0659

FIDS reimbursement is subject to post-payment audit action, including the prospective elimination of a provider's supplemental payment if the provider submits claims for FIDS services not provided in an approved FIDS area.

(Subsection 10.14 Rate Relief for Class I Nursing Facilities was removed per bulletin MMP 24-55. This included the following subsections:

- **10.14.A. Eligibility Criteria**
- **10.14.B. Rate Relief Petition Process**
- **10.14.C. Rate Relief Agreement**
- **10.14.D. Rate Relief Period**
- **10.14.E. Withdrawal of Rate Relief Agreement**
- **10.14.F. Rate Relief Appeals**
- **10.14.G. Rate Relief for a New Provider in a Medicaid-Enrolled Nursing Facility With a Variable Rate Base Less Than or Equal to 80 Percent of the Class Average Variable Cost**
- **10.14.G.1. Rate Relief Methodology**
- **10.14.H. Rate Relief for a Current Provider or a New Provider in a Medicaid Enrolled Nursing Facility With a Variable Rate Base Between 80 Percent and 100 Percent of the Class Average Variable Cost**
- **10.14.H.1. Rate Relief Methodology**
- **10.14.I. Rate Relief for a Current Provider in a Medicaid Enrolled Nursing Home Facility With a Variable Rate Base Less Than or Equal to 60 Percent of the Variable Cost Limit**
- **10.14.I.1. Rate Relief Methodology)**

10.14 County Medical Care Facilities Special Payments (CMCFSP) Program [Re-numbered 4/1/2025]

Eligible County Medical Care Facilities (CMCF) may receive special payments for unreimbursed costs incurred for services to Medicaid beneficiaries. Allocations to individual facilities will be determined based upon unreimbursed costs certified as public expenditures in accordance with the Code of Federal Regulations (CFR) 42 CFR 433.51. MDHHS will make special payments to CMCFs who provided services to Medicaid beneficiaries for dates of service on and after January 1, 2009.

10.14.A. Eligibility for CMCFSP Program [Re-numbered 4/1/2025]

To be eligible for participation in the CMCFSP Program, each provider must meet the following conditions:

- The provider must be a county-owned and -operated licensed CMCF.
- The provider must be certified to serve Medicaid beneficiaries.
- The provider must have reported Medicaid bed days during the fiscal year covered.
- The provider must have incurred allowable costs in excess of Medicaid reimbursement for Medicaid bed days reported during the fiscal year covered.

10.14.B. Enrollment in CMCFSP Program [Re-numbered 4/1/2025]

To participate in the CMCFSP Program, a Medicaid-participating CMCF must submit a signed copy of the Attestation of Participation form to the MDHHS LTC Reimbursement

and Rate Setting Section (RARSS). (Refer to the Directory Appendix for contact information.) Providers must acknowledge and agree to the terms of participation in the CMCFSP Program as outlined in this section and in the attestation form.

If a provider desires to receive interim payments during their fiscal year, the request to participate in the CMCFSP Program must be received prior to that fiscal year for which participation is desired. A provider may also wait to submit a request to participate until the filing of their annual Medicaid cost report. If a provider opts to participate when they file their annual cost report, the provider may receive payments for unreimbursed costs through the initial and final reconciliation but will not receive interim payments.

If participation is approved, RARSS will enroll the provider in the CMCFSP Program in the provider's fiscal year following the approval of RARSS. The provider must submit an attestation form for each year that the provider desires to participate in the CMCFSP Program.

10.14.C. Calculation of CMCFSP Payment [Re-numbered 4/1/2025]

An interim payment and reconciliation process will be employed to make payments to qualifying facilities. Allowable unreimbursed costs for services provided to Medicaid beneficiaries will be determined from information reported on the most recently filed cost report. Allowable unreimbursed costs are defined as total allowable Medicaid routine costs before formula limitations minus total Medicaid routine services revenue received. Medicaid routine services revenue includes all revenues received for Medicaid routine services, including all supplemental/enhanced payments (e.g., Net QAS, Net QMI Amount, etc.) from the State and all payments received from residents and other payers for the same services. Costs will be trended to the current state fiscal year using an inflation factor, without capital, taken from the Health Care Cost Review, which is published quarterly by Global Insight. Interim payments will then be made to qualifying CMCFs.

10.14.D. Reconciliation Process [Re-numbered 4/1/2025]

Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on allowable Medicaid costs. Information needed to reconcile initial payments will be obtained from the cost report filed with MDHHS for the applicable reporting period. Second, payments will be readjusted based on changes to the filed cost report for the applicable reporting period, resulting from an audit of that cost report conducted by MDHHS.

Facilities receiving special payments for unreimbursed Medicaid costs are liable for any overpayment amount identified in the reconciliation process. Providers must repay any overpayment amount within 120 days of the date of notification of overpayment.

SECTION 11 - APPEAL PROCESS

A nursing facility participating in the Medicaid program may appeal an adverse action and certain determinations made by Medicaid. The provider will be given a written notice of the determination or action that outlines the proposed action, the provider's appeal rights, and the appeal process.

Adverse actions include, but are not limited to:

- A suspension or termination of a provider's Medicaid program participation.
- A reduction, suspension, or adjustment of provider payments.
- A retroactive adjustment following an audit or review of a facility's daily reimbursement rate or other services reimbursement.
- The prospective reimbursement rate determination.

Some elements of the Medicaid nursing facility reimbursement determination methodology are not appealed through an administrative process, but may be appealed to a court of appropriate jurisdiction. These are elements where an administrative remedy, if permitted for a single provider, would imply or necessitate a change for all providers or for all providers in a class and include, but are not limited to:

- The formula for the determination of the nursing facility cost factor.
- The Principles of Reimbursement and guidelines that define allowable costs.
- Non-Medicaid issues.
- Cost limits established in program policy.
- Medicaid's determination of allowable items and costs until an audit has been completed.

The provider retains their right to an administrative hearing regardless of the outcome of the internal conference. The provider may waive the internal conference and directly request an administrative hearing. The review and hearings process for providers has been promulgated in the administrative rules located on LARA's website. The process is explained in more detail in the MDHHS Administrative Hearing pamphlet on the MDHHS website. (Refer to the Directory Appendix for website information.)

11.1 AUDIT APPEALS

Each nursing facility cost report is audited to ensure that expenses were reported in adherence with Medicaid policy. Once the Exit Meeting is completed or waived, the provider is given a Preliminary Summary of Audit Adjustments Notice via File Transfer. This notice outlines audit results, serves as the adverse action notice, and advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Preliminary Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings.

If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments Notice within 30 calendar days of the date of the notice, then the Preliminary Summary of Audit Adjustments Notice will serve as the Final Summary of Audit Adjustments Notice. If the appeal process is exhausted, the provider will receive a Final Summary of Audit Adjustments Notice. The Final

Summary of Audit Adjustments Notice outlines the final audit results and may not be appealed. A Preliminary Summary of Audit Adjustments Notice that serves as a Final Summary of Audit Adjustments Notice is also not appealable.

To ensure faster processing of final settlements, a provider should notify MDHHS via File Transfer if they are not appealing any of the audit adjustments in the Preliminary Summary of Audit Adjustments Notice.

If a provider does not appeal or does not respond to the Preliminary Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review.

11.2 Rate Appeals

Providers are notified in writing of their Medicaid reimbursement rate(s) at least 30 calendar days prior to the rate's effective date. The provider is given an opportunity for informal review of the rate determination by RARSS. The provider may also formally appeal issues of disagreement or dispute regarding the determined reimbursement rate. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Medicaid Reimbursement.

11.3 Reimbursement Settlement Appeals

A final settlement reimbursement determination is made to determine the aggregate Medicaid reimbursement to the nursing facility for the period covered by the cost report. Providers are notified in writing of the final reimbursement settlement and given an opportunity for informal review of the settlement determination. The provider may formally appeal issues of disagreement or dispute of the reimbursement settlement determination. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Program Reimbursement.

11.4 Provisional Rates

A provider will be given a provisional rate for the new rate year if:

- Medicaid is responsible for a delay in determination procedures.
- An Area Office Conference or Administrative Conference is in progress.
- The potential for an Area Office Conference or an Administrative Conference is still open at the beginning of the rate year that begins a year and a day after the end of the rate year that is being processed.

For this purpose, "delay in the procedures" means (if applicable):

- Medicaid failed to issue the Preliminary Summary of Audit Adjustments in a timely manner.
- Medicaid failed to conduct the Area Office Conference in a timely manner.
- Medicaid failed to issue the Final Summary of Audit Adjustments Notice, including a final determination notice, in a timely manner.

11.5 Provider Payment Adjustment Resulting From Appeal Decision

If the appeal result requires a change in a provider's rate or reimbursement level, the change will be made retroactively for service periods coinciding with the effective dates of the original reimbursement rate notice. Payment adjustments will be made by an aggregate adjustment rather than by individual claim adjustments.

SECTION 12 – DIRECT CARE WORKER WAGE INCREASE FOR PERSONAL CARE SERVICES

The direct care worker wage increase is consistent with the final State fiscal year budget and is available for eligible clinical and non-clinical direct care workers providing in-person direct care for Medicaid beneficiaries in Medicaid-certified nursing facilities. This payment applies to base hourly wages that were in effect on September 30 of the previous fiscal year and includes any associated share of employer Federal Insurance Contributions Act (FICA) payroll taxes. Any subsequent wage increases will be according to the applicable fee schedule found on the MDHHS website. (Refer to the Directory Appendix for website information.)

- Eligible clinical direct care workers include registered nurses, licensed practical nurses, competency-evaluated nursing assistants, and respiratory therapists employed by Medicaid-certified nursing facilities.
- Eligible non-clinical workers include Medicaid-certified nursing facility employees whose costs are reported in the following job classifications in nursing facility institutional cost reports: other housekeeping, other maintenance worker, other plant operations, other laundry, dining room assistants, other dietary worker, other medical records, other social services, other diversion therapy, beauty and barber, gift, flower, coffee and canteen worker.
  - An employee in a non-direct care position (e.g., recreation coordinator, administrator) who also has a current license as a Registered Nurse, Licensed Practical Nurse or respiratory therapist, or current certification as a competency-evaluated nursing assistant is eligible for the wage increase only for hours worked providing direct care.
  - A nursing assistant who has not completed the evaluation for certification is not eligible for the wage increase.
  - An administrative or support employee providing direct care does not qualify if that person does not have the qualifying license or certification.
  - Any qualifying administrative or support employee providing direct care is required to remain in compliance with all federal laws applied in CFR 483.35 (b)(1)-(3). (Refer to the Directory Appendix for website information.)
  - State employees are not eligible for the wage increase.

12.1 ADMINISTRATION OF PREMIUM PAY

- For eligible clinical direct and indirect care staff, the hourly wage increase should be a base wage increase paid above the worker's regular wage paid or starting wage offered to eligible staff on September 30 of the previous fiscal year.
- The wage increase payment cannot be used to supplant other wage increases.
- The wage increase must be applied entirely to eligible employee wages. Any associated share of employer Federal Insurance Contributions Act (FICA) payroll taxes must also be paid.
- The wage increase must be paid to employees prior to requesting reimbursement from MDHHS and on at least a monthly basis. Any nursing facility who holds employee owed wage increases

in a bank account for any period of time shall be required to reimburse MDHHS for any accumulated interest associated with the payments.

- The wage increase applies to overtime hours for non-exempt employees (including those employees covered by the "8 and 80" overtime system) at a time-and-a-half rate per hour for clinical workers and non-clinical workers providing direct care.
  - For example, if the current wage increase amount was $3.40 for clinical and $0.85 for non-clinical and an employee works 43 hours in a week and is not covered by the "8 and 80" overtime system, they would be eligible for 3 hours of overtime and the wage increase would be $5.10 per hour for a clinical worker and $1.28 per hour for the non-clinical worker for the 3 overtime hours.
  - If an eligible employee providing direct care is paid on a salary basis, the wage increase for a regular work week would be $136 (40 hours x $3.40) or $272 (80 hours x $3.40) in a two-week period for a clinical worker and $34 (40 hours x $0.85) for a regular work week or $68 (80 hours x $0.85) in a two-week period for a non-clinical worker.
  - A nursing facility is eligible for reimbursement for employee payroll tax expenses directly related to the $3.40 and $0.85 per hour wage increase and $5.10 and $1.28 per hour overtime wage increase.
- The wage increase does not apply to employer contributions to the employee's retirement plan.
- Additional funding is not available to the nursing facility for Worker's Compensation, unemployment insurance costs or other additional administrative costs associated with the wage increase funding.
- The wage increase is a direct pass-through separate from the Medicaid nursing facility per diem.
- An employee eligible for the wage increase may elect to not receive the payment. This decision must be documented in writing or electronically by the employee.
- This funding is subject to audit and recoupment if these funds are not used for their intended purpose.

12.2 Reporting

Updated Wage Pass-Through forms, as well as more information regarding administration of the wage increase for skilled nursing facilities, can be found in a Frequently Asked Questions document found on the MDHHS website. (Refer to the Directory Appendix for website information.)

- Nursing homes must complete the Nursing Home Direct Care Worker and Non-Clinical Staff Wage Pass-Through Reimbursement form (MDHHS-5919-A) and submit to MDHHS for reimbursement. (Refer to the Directory Appendix for website information.) Completed forms should be submitted on a monthly or bi-weekly basis. Nursing facilities must maintain payroll and personnel records to support wage increases to eligible employees for direct care hours worked, including overtime hours. As with all MDHHS payments to providers, wage increase funds are subject to audit and recovery of inappropriate payments.
- Nursing facilities should not send to MDHHS any information that is specific to an individual employee. Employee-specific information must be maintained by the nursing facility for audit purposes. If the documentation is required for an audit, it must be submitted using a secure method.

SECTION 13 – APPRAISAL GUIDELINES

Where historical cost records of a purchased asset are not available or are incomplete, or where fair market value or current reproduction cost must be established, a timely appraisal of the historical costs, fair market value, or depreciated reproduction cost (as appropriate) of the asset made by an independent, recognized expert is acceptable for depreciation and owner's equity capital purposes. The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal must be conducted in accordance with "The Principles of Appraisal Practices and Code of Ethics" of the American Society of Appraisers.

For Medicaid program purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value, or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

Appraisal Date	The date selected for establishing the value of fixed assets. For example, if December 31, 2017 was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, 2018, any additions or dispositions of fixed assets between December 31, 2017 and February 1, 2018 must be taken into account in the appraisal values.
Appraised Book Value	The book value of an asset's appraised cost as of the date of acquisition less accumulated depreciation computed on an approved basis up to the appraisal date.
Appraisal Expert	An individual or firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishment or reconstruction of the historical cost, fair market value, or current reproduction cost of such assets. The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the reimbursement principles, particularly those pertinent to depreciation.

13.1 APPROVAL

Medicaid does not require the nursing facility representatives to get prior approval before an appraisal is made for Medicaid purposes. Medicaid requirements are that the appraisal be conducted in accordance with the provisions of these guidelines. Questions regarding the appraisal of the nursing facility should be directed to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS). (Refer to the Directory Appendix for contact information.) The provider must make the appraisal agreement and final report available to Agency staff for audit review. The scope of the appraisal must conform to Medicare Principles of Reimbursement as modified by Michigan Medicaid for provider costs in effect on the appraisal date.

13.2 NEED FOR APPRAISAL

An appraisal for Medicaid purposes should be made only where the nursing facility provider has no historical cost records, has incomplete records of the depreciable fixed assets, or needs to determine an asset's fair market value or depreciated reproduction cost. The appraisal should develop the historical cost and related information that will assist in the construction, reconstruction, or revision of accounting records to enable the provider to make proper distribution of depreciation expense in cost reports.

Normally, a proprietary provider will not need a historical cost basis of its assets. Where an appraisal is being performed to determine the current reproduction of an asset, the appraisal should represent the cost to reproduce the actual facility in like kind and should not be inflated by such factors as current or anticipated space needs or different construction types, e.g., masonry versus wood frame. Appraisals must be performed within the time limit specified in the proposed agreement and not on a piecemeal or intermittent basis.

13.3 Purchase of Ongoing Facility

In establishing the historical cost of assets where an ongoing nursing facility is purchased through a bona fide sale after July 1, 1966 and prior to August 1, 1970, the purchase price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets must not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale or the fair market value of the tangible assets purchased.

If the nursing facility was participating in the Medicaid program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new facility owner (the purchaser) in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price. The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to resident care) in accordance with the fair market value of each asset as it was used by the seller at the time of sale. If the purchaser and seller cannot agree on an allocation of sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the SMA will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal. In any case, the sale price must be allocated among all the assets sold, even if some of the assets will be disposed of shortly after the sale.

If a purchaser cannot demonstrate that the sale is bona fide, the seller's net book value will be used by the purchaser as the basis for depreciation of the asset. In such cases, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the Medicaid program, and these must be considered as incurred by the purchaser for Medicaid purposes.

The cost basis for the depreciable assets of a nursing facility purchased in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following:

- The total price paid for the facility by the purchaser as allocated to the individual assets;
- The total fair market value of the facility at the time of the sale as allocated to the individual assets;
- The combined fair market value of the individually identified assets at the time of the sale; or
- The current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.

The purchaser has the burden of proving that the transaction was a bona fide sale, and if the burden is not met, the cost basis may also not exceed the seller's cost basis less accumulated depreciation.

13.4 Fixed Assets Included in Appraised Values

Fixed asset values established by an appraisal must include all plant assets owned by the nursing facility provider that are used in resident care or in the overall operation and administration of the facility. Fixed assets used in research and other non-allowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering resident care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset values established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not betterment or improvement but an expense of that period.

The pricing of assets to establish historical costs is based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices, such other records as revenue stamps, board minutes, contracts of purchase, and deeds recorded with the county's Recorder of Deeds may be used.

Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indices may be used to establish acquisition costs and dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to the manufacturers and to quantity discounts. The determined value should closely approximate the actual historical cost of an asset at the date of acquisition.

13.5 Minor Equipment [Change Made 4/1/2025]

Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense. If the cost was capitalized on the financial statements, then it must be reported on Worksheet 3. **(text added 4/1/2025)**

Minor equipment includes, but is not limited to, such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets. The general characteristics of this type of equipment are as follows:

- The equipment is in no fixed location and is subject to use by various departments in the nursing facility;
- The items are comparatively small in size and unit cost;
- The equipment is subject to inventory control;
- There is a fairly large quantity of the items in use; and

- The equipment has a useful life of approximately three years or less.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, the Medicaid program will not recognize a historical cost of such assets in excess of the historical cost used for federal income tax purposes. Nursing facility providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the SMA will consider the provider's federal income tax returns as secondary evidence to be used in establishing and verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions within the Medicare Principles of Reimbursement, such as "cost to related organizations," the historical cost under Medicaid might be less than that allowed and used for income tax purposes.

Under the Principles, nursing facility providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicaid purposes. The Principles do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures that were not capitalized but were considered as expense items.

Example: If a provider determines that a physical modification of the building was a repair, and thus an item of expense not capitalized, and uses the historical cost so determined for federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it, i.e., increase the historical cost basis of the building for Medicaid purposes.

Example: If a provider builds a facility and, in establishing the historical cost of the building, determines that material and labor used were not part of the historical cost of the building and charges the cost of such material and labor into expenses for federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicaid purposes.

Costs in excess of the cost basis used for federal income tax purposes will not be recognized under Medicaid. Further, for cost reporting periods beginning on or after January 1, 1970, the SMA will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the Medicaid program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value will be used for computations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicaid.

13.6 Donated Assets

The fair market value for a donated asset is the price that the asset would bring by bona fide bargaining between well-informed purchasers and sellers at the date of acquisition. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.

Exception: In cases where an asset has been used or depreciated under the Medicaid program and then donated to a provider, the basis of depreciation will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

If the nursing facility provider's records do not include the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

Where material, labor, and services are donated in the construction of an asset, the asset value is the sum of the appraised cost of the material, labor, or services actually donated and the incurred cost of that part which was not donated. Labor costs should be determined in accordance with both the rates prevailing in the community at the time of construction and the type of labor incurred, i.e., if the labor donated was non-union labor, the cost would be at the non-union labor rate rather than at a union labor rate. If records are not available as to the actual labor, services, or material donated, the fair market value at the time of donation may be determined by the other methods shown in Medicare Principles of Reimbursement. Estimated labor costs provided by an owner or shareholder of a facility are not includable in the historical cost of constructed assets.

13.7 Assets Costing Less Than $100

Individual major movable assets costing less than $100, whether or not purchased in quantity prior to the appraisal date, may be capitalized at the time of appraisal at the purchase cost less accumulated depreciation from the date of acquisition regardless of the provider's past accounting practices. If an election is made to capitalize such assets, this policy must be applied consistently.

Nursing facility providers that have expensed such items while in the Medicaid program may not decide later to capitalize them. This also applies to those providers that eventually decide to have appraisals. The appraisal expert may group major movable equipment with a unit cost of $100 or less. However, the book value assigned to such grouped assets at appraisal may not exceed the book value of the assets if individually appraised. Identification of the individual assets comprising the group must be available.

13.8 Tagging of Equipment

For Medicaid program purposes, tagging of equipment is not mandatory. In the absence of tagging, however, alternate records must be maintained to satisfy audit verification of the existence and location of the assets.

13.9 Appraisal Programs

Since the condition of nursing facility provider asset records varies significantly, an appraisal program may be comprehensive or partial. For instance, a provider may engage an appraisal expert to appraise a part of its facility for which no historical records have been maintained, or a provider may need to have an appraisal made on a particular class of assets in a specific identified location.

Comprehensive appraisal programs are usually appropriate because of such complexities as lump-sum purchases of assets or a complete lack of historical cost records for all assets.

An appraisal program should include:

- A physical inventory and listing of pertinent data for all applicable assets in use or in standby status as of the appraisal date or report date. The physical inventory may be made by the provider or by the appraiser. If made by the provider, the appraiser must verify the inventory.
- The acquisition cost of each item or unit of property including, but not limited to, architect fees, installation costs, and freight.
- A classification of each item or unit of property in accordance with the American Hospital Association (AHA) Health Data and Coding Standards Group, Estimated Useful Lives of Depreciable Hospital Assets. These classifications are:
  - Land improvements;
  - Buildings, including building improvement, fixed equipment, building services equipment and other fixed equipment;
  - Major movable equipment;
  - Minor equipment; and
  - Leasehold equipment.

  Note: Refer to the Cost Classifications and Cost Finding section of this appendix for a comprehensive description for capital assets by category.
- Establishing an estimated useful life for each asset. The estimated useful life for purposes of the appraisal must be consistent with the estimated useful life for each asset used by the provider for depreciation purposes.
- Determining a salvage value for each asset.
- Selecting a depreciation method for each asset.
- Calculating depreciation provisions for the current reporting period.
- Calculating accumulated depreciation using an approved basis, from the date of acquisition to the start of the Medicaid reporting period in which actual depreciation is first claimed.
- Determining square footage for each cost center to identify all rooms on a floor or within a building if the provider did not previously do this. This should be accomplished as explained in the AHA Cost Finding and Rate Setting for Hospitals publication.
- Reconciling appraisal results with provider records. For assets acquired prior to January 1, 1966, the provider's plant asset records, if any, and accounting records must be considered even though they may be inaccurate. This reconciliation must be made for land improvements, buildings, building services equipment and, where possible, for other major asset classifications.

  Where applicable, differences discussed by the reconciliation must be reflected as adjustments in the provider's accounting and plant asset records.

13.10 Appraisal Report

The appraisal expert must prepare a letter of certification. The letter should state that, in the appraisal expert's judgment, the appraisal results were determined in conformity with Medicaid program regulations and requirements. This letter will include such information as:

- Name of the nursing facility provider for which the appraisal was conducted;
- Location(s) of the facility included in the appraisal;
- Appraisal date, the date up to which accumulated depreciation was calculated (if other than the appraisal date), and the period for which current depreciation is calculated;
- Contents of data supplied to the provider, i.e., summaries, schedules, plans, etc.;
- Appraisal program descriptions, including:
  - The extent of asset appraisal, i.e., assets physically inventoried,
  - Pricing basis, and
  - Other pertinent information not readily apparent in the detail results, such as depreciation methods;
- Policy for determining capitalizable assets;
- Depreciation policy in the year of acquisition and disposal; and
- Identification of material items included in the appraisal where the values of such items were obtained from outside sources without independent verification by the appraisal expert.

13.11 Listing of Assets Appraised

If a listing of assets that constitutes the nursing facility provider's Medicaid property records is supplied, it must contain all necessary and pertinent information, even if portions were determined solely by the provider. A listing of assets should include the following information for each asset:

- Building location;
- Cost center or department;
- Asset description, usually including manufacturer's name, model number, serial number, etc.;
- AHA asset classification;
- Historical cost;
- Acquisition date;
- Estimated useful life to provider;
- Salvage value;
- Depreciation provision for current reporting period;
- Accumulated depreciation provision for current reporting period; and
- Pricing method necessary for adequate disclosure, where more than one method was used for various assets.

Reconciliations and comparisons with provider records must also be included, as well as square footage and other allocation basis information for buildings and cost centers within buildings.

13.12 Records

Appraisal work papers must be made available to SMA staff or their designee upon reasonable request.

13.13 Appraisal Expense

The expense of an appraisal to establish plant records for Medicaid program purposes, including the expense for appraisal of research and other non-resident departments incurred by a nursing facility provider after entrance into the program, may be included as an allowable cost. The expenses will be considered as administrative costs in the period incurred, subject to apportionment to the Medicaid program. Appraisal expenses incurred relative to assets not connected with provider operations are not allowable costs.

Where providers have appraisals made for other business purposes, such as insurance coverage, tax values or financing, the incurred expenses for such appraisals may be included in allowable costs as part of administrative and general costs. However, appraisal expenses incurred to establish values for the sale or anticipated sale of the nursing facility or provider organization are not allowable costs.

Where the SMA determines that a provider has incurred appraisal expenses to establish the historical cost of assets which were already adequately reflected in its books, records, or tax returns, the cost of performing the appraisal is not allowable.

SECTION 14 – COST REPORTING AND REIMBURSEMENT DESCRIPTIONS AND CLASSIFICATIONS

14.1 GENERAL

Refer to Cost Classifications and Cost Finding section of this appendix for detailed discussion and description of program cost categories for Plant, Variable Base, Support and Base/Support.

Plant 1	Depreciation cost category generally allocated to operational cost centers on the basis of square footage.
Plant 2	Depreciation cost category generally allocated to operational cost centers on the basis of square footage or asset dollar value.
Plant 3	Interest, real and personal property taxes, allowable lease rental and borrowing-related amortization cost category generally allocated to operational cost centers on the basis of square footage.

14.2 PLANT COSTS

Rent/Leases

Leases ..... Plant 1
Underlying Cost – Depreciation ..... Plant 1
Underlying Cost – Interest ..... Plant 3
Underlying Cost – Property Taxes ..... Plant 3
Lease Rental Component ..... Plant 3
Other Nonallowable Costs ..... Support

Interests

Mortgage & Bond ..... Plant 3
Other ..... Plant 3
Paid to Owner(s) ..... Plant 3

Amortization

Interest Related ..... Plant 3

Property Taxes

Property Taxes ..... Plant 3

Depreciation

Building & Improvements (fixed) ..... Plant 1
Equipment (moveable) ..... Plant 2
Vehicles ..... Plant 2

14.3 EMPLOYEE HEALTH & WELFARE

FICA – Employer's Portion ..... Base/Support
Federal Unemployment Tax ..... Base/Support

MESC	Base/Support
Workers' Compensation	Base/Support
Pension & Profit Sharing	Base/Support
Employees Group Insurance	Base/Support
Retirement	Base/Support
Other	Base/Support

14.4 Administrative & General

Salaries & Wages – Officers	Support
Salaries & Wages – Administrator	Support
Salaries & Wages – Owner/Administrator	Support
Salaries & Wages – Clerical & Other	Support
Employee Benefits	Support
Workers Compensation	Base
Payroll Taxes	Support
Director's Fees	Support
Management Services	Support
Central Office Overhead	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Advertising	Support
Promotion & Public Relations	Support
Telephone & Other Communications	Support
Dues & Subscriptions	Support
Insurance - Officer's Life	Support
Insurance – General	Support
Malpractice Liability Insurance	Support
Copier	Support
License Fees	Support
Quality Assurance Assessment – Long Term Care	Support
Quality Assurance Assessment – Hospital (non-Long Term Care)	Support
Quality Measure Initiative Assessment	Support
Provider Donation for Outstationed State Staff	Support
Transportation	Support
Equipment Repair & Maintenance	Support
Vehicles	Support
Office Supplies	Support
Printing	Support
Postage, UPS, Freight	Support
Legal & Accounting	Support
Utilization Review	Support
Income Taxes	Support
Other Taxes	Support
General Travel	Support
Travel & Seminars	Support
Data Processing	Support
Amortization – Non-interest Related	Support

Employment Agency Fees	Support
Employee Background Check Fees	Support
Employee Fingerprinting Fees	Support
Charitable Contributions	Support
Minor Equipment – Less Than $5,000	Support
Minor Equipment – More Than $5,000	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Security Guard Services	Support
Penalties	Support
Miscellaneous	Support
Bad Debt	Support

14.5 Plant Operation & Maintenance

Salaries & Wages – Plant Operation & Maintenance	Support
Employee Benefits	Support
Workers' Compensation	Base
Payroll Taxes	Support
Contracted Services	Support
In-service Training	Support
Education	Support
Minor Equipment – Less Than $5,000	Support
Minor Equipment – More Than $5,000	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Deprecation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Repair & Maintenance – Building	Support
Repair & Maintenance – Equipment	Support
Repair & Maintenance – Grounds	Support
Building Insurance	Support
Supplies	Support
Miscellaneous	Support
Trash Removal	Support
Snow Removal	Support

14.6 Utilities

Gas & Fuel	Base
Electricity	Base
Water	Base
Miscellaneous	Base

14.7 LAUNDRY

Salaries & Wages – Laundry ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base
Payroll Taxes ..... Base
Contracted Services – Base ..... Base
Contracted Services – Support ..... Support
Contracted Services – Base/Support ..... Base/Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $5,000 ..... Support
Minor Equipment – More Than $5,000 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Linen & Bedding ..... Base
Laundry Supplies ..... Base
Miscellaneous – Base ..... Base
Miscellaneous – Support ..... Support

14.8 HOUSEKEEPING

Salaries & Wages – Housekeeping ..... Support
Employee Benefits ..... Support
Workers' Compensation ..... Base
Payroll Taxes ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $5,000 ..... Support
Minor Equipment – More Than $5,000 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Repair & Maintenance ..... Support
Housekeeping Supplies ..... Support
Miscellaneous ..... Support

14.9 DIETARY

Salaries & Wages – Dietary ..... Base
Employee Benefits ..... Base
Workers' Compensation ..... Base

Payroll Taxes	Base
Contracted Services – Base	Base
Contracted Services – Support	Support
Contracted Services – Base/Support	Base/Support
In-service Training	Support
Salaries & Wages – In-service Training	Support
Employee Benefits – In-service Training	Support
Payroll Taxes – In-service Training	Support
Education	Support
Minor Equipment – Less Than $5,000	Support
Minor Equipment – More Than $5,000	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Repair & Maintenance	Support
Raw Food	Base
Dietary Supplies (Non-Ingested)	Base
Miscellaneous – Base	Base
Miscellaneous – Support	Support

14.10 Nursing Administration

Salaries & Wages – Director of Nursing	Base
Salaries & Wages – Other	Base
Employee Benefits	Base
Workers' Compensation	Base
Payroll Taxes	Base
Office Supplies	Support
Contracted Services – Base	Base
Contracted Services – Support	Support
Contracted Services – Base/Support	Base/Support
Salaries & Wages – In-service Trainer	Support
Employee Benefits – In-service Trainer	Support
Payroll Taxes – In-service Trainer	Support
In-service Training	Support
Salaries & Wages – In-service Training	Support
Employee Benefits – In-service Training	Support
Payroll Taxes – In-service Training	Support
Education	Support
Minor Equipment – Less Than $5,000	Support
Minor Equipment – More Than $5,000	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation	Plant 2
Direct Allocation – Interest & Property Taxes	Plant 3
Miscellaneous – Base	Base

Miscellaneous – Support ..... Support

14.11 Central Supplies

Salaries & Wages – Central Supplies ..... Support
Employee Benefits ..... Support
Workers' Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Support
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $5,000 ..... Support
Minor Equipment – More Than $5,000 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

14.12 Medical Supplies

Salaries & Wages – Medical Supplies ..... Support
Employee Benefits ..... Support
Workers' Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Base
Contracted Services ..... Support
In-service Training ..... Support
Education ..... Support
Minor Equipment – Less Than $5,000 ..... Support
Minor Equipment – More Than $5,000 ..... Plant 2
Equipment Rental – Less Than 12 Months ..... Support
Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
Direct Allocation – Moveable Equipment Depreciation ..... Plant 2
Direct Allocation – Interest & Property Taxes ..... Plant 3
Miscellaneous ..... Support

14.13 Medical Records & Library

Salaries & Wages – Medical Director ..... Support
Salaries & Wages – Medical Records ..... Support
Employee Benefits ..... Support
Workers' Compensation ..... Base
Payroll Taxes ..... Support
Supplies ..... Support
Contracted Services – Medical Director ..... Support

Contracted Services..... Support
In-service Training..... Support
Education..... Support
Minor Equipment – Less Than $5,000..... Support
Minor Equipment – More Than $5,000..... Plant 2
Equipment Rental – Less Than 12 Months..... Support
Equipment Rental – More Than 12 Months..... Plant 2
Direct Allocation – Fixed Assets Depreciation..... Plant 1
Direct Allocation – Moveable Equipment Depreciation..... Plant 2
Direct Allocation – Interest & Property Taxes..... Plant 3
Miscellaneous..... Support

14.14 Social Services

Salaries & Wages – Social Services..... Base
Employee Benefits..... Base
Workers' Compensation..... Base
Payroll Taxes..... Base
Supplies..... Support
Contracted Services – Base..... Base
Contracted Services - Support..... Support
Contracted Services – Base/Support..... Base/Support
In-service Training..... Support
Education..... Support
Minor Equipment – Less Than $5,000..... Support
Minor Equipment – More Than $5,000..... Plant 2
Equipment Rental – Less Than 12 Months..... Support
Equipment Rental – More Than 12 Months..... Plant 2
Direct Allocation – Fixed Assets Depreciation..... Plant 1
Direct Allocation – Moveable Equipment Depreciation..... Plant 2
Direct Allocation – Interest & Property Taxes..... Plant 3
Miscellaneous – Base..... Base
Miscellaneous – Support..... Support

14.15 Diversional Therapy

Salaries & Wages - Diversional Therapy..... Base
Employee Benefits..... Base
Workers' Compensation..... Base
Payroll Taxes..... Base
Supplies..... Base
Contracted Services – Base..... Base
Contracted Services - Support..... Support
Contracted Services – Base/Support..... Base/Support
In-service Training..... Support
Education..... Support
Minor Equipment – Less Than $5,000..... Support
Minor Equipment – More Than $5,000..... Plant 2
Equipment Rental – Less Than 12 Months..... Support

Equipment Rental – More Than 12 Months ..... Plant 2
Direct Allocation – Fixed Assets Depreciation ..... Plant 1
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Miscellaneous – Base..... Base
Miscellaneous – Support ..... Support

14.16 Ancillary Service Cost Centers

14.16.A. Radiology

Salaries & Wages – Radiology .....Support
Employee Benefits.....Support
Payroll Taxes .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
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Contracted Outside Services.....Support
Other .....Support

14.16.B. Laboratory

Salaries & Wages – Laboratory .....Support
Employee Benefits.....Support
Payroll Taxes .....Support
Minor Equipment – Less Than $5,000 .....Support
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Contracted Outside Services.....Support
Other .....Support

14.16.C. Intravenous Therapy

Salaries & Wages – Intravenous Therapy .....Support
Employee Benefits.....Support
Payroll Taxes .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
Direct Allocation – Fixed Assets Depreciation .....Plant 1

Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other.....Support

14.16.D. Inhalation Therapy (Oxygen)

Salaries & Wages – Inhalation Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Oxygen – Intermittent Use.....Base
Oxygen – Continuous Use.....Support
Minor Equipment – Less Than $5,000.....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.E. Physical Therapy

Salaries & Wages – Physical Therapy.....Support
Employee Benefits.....Support
Minor Equipment – Less Than $5,000.....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
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Payroll Taxes.....Support
Contracted Outside Services.....Support
Other.....Support

14.16.F. Speech Therapy

Salaries & Wages – Speech Therapy.....Support
Employee Benefits.....Support
Payroll Taxes.....Support
Minor Equipment – Less Than $5,000.....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
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Contracted Outside Services.....Support
Other.....Support

14.16.G. Occupational Therapy

Salaries & Wages – Occupational Therapy .....Support
Employee Benefits.....Support
Payroll Taxes .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Contracted Outside Services.....Support
Other .....Support

14.16.H. Electroencephalography

Salaries & Wages – Electroencephalography .....Support
Employee Benefits.....Support
Payroll Taxes .....Support
Electroencephalography.....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3

14.16.I. Medical Supplies Charged to Patient

Medical Supplies - Chargeable .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Interest & Property Taxes.....Plant 3
Other .....Support

14.16.J. Pharmacy

Salaries & Wages – Pharmacy .....Support
Employee Benefits - Pharmacy .....Support
Payroll Taxes - Pharmacy.....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support

Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Moveable Equipment Depreciation .....Plant 2
Direct Allocation – Interest & Property Taxes .....Plant 3
Contracted Outside Services .....Support
Pharmacy - Other .....Support
Drugs – Legend .....Base
Drugs – Non-Legend .....Support
Special Services .....Support

14.16.K. PHYSICIAN SERVICES

Salaries & Wages – Physician Services .....Support
Employee Benefits .....Support
Payroll Taxes .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000 .....Plant 2
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Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Moveable Equipment Depreciation .....Plant 2
Direct Allocation – Interest & Property Taxes .....Plant 3
Contracted Outside Services .....Support
Other .....Support

14.17 NURSING SERVICE COST CENTERS

14.17.A. MEDICARE SNF UNIT

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies .....Base
Employee Benefits .....Base
Workers' Compensation .....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services .....Base
In-service Training .....Support
Education .....Support
Salaries & Wages – In-service Training .....Support
Employee Benefits – In-service Training .....Support
Payroll Taxes – In-service Training .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000 .....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
Direct Allocation – Fixed Assets Depreciation .....Plant 1
Direct Allocation – Moveable Equipment Depreciation .....Plant 2
Direct Allocation – Interest & Property Taxes .....Plant 3

Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.17.B. MEDICAID ROUTINE CARE UNIT #1

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers' Compensation .....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Salaries & Wages – In-service Training .....Support
Employee Benefits – In-service Training.....Support
Payroll Taxes – In-service Training .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
Direct Allocation – Fixed Assets Depreciation .....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.17.C. MEDICAID ROUTINE CARE UNIT #2

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers' Compensation .....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Salaries & Wages – In-service Training .....Support
Employee Benefits – In-service Training.....Support
Payroll Taxes – In-service Training .....Support
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Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.D. Medicaid Special Care Unit #1

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers Compensation.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Salaries & Wages – In-service Training .....Support
Employee Benefits – In-service Training.....Support
Payroll Taxes – In-service Training .....Support
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Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.17.E. Adult Daycare Program

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Workers' Compensation .....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
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Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base

Miscellaneous – Support .....Support

14.17.F. Home For Aged Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
Direct Allocation – Fixed Assets Depreciation .....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.17.G. Non-LTC Apartment/Housing Unit

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes .....Base
Nursing Supplies .....Base
Contracted Services.....Base
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $5,000 .....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months .....Support
Equipment Rental – More Than 12 Months .....Plant 2
Direct Allocation – Fixed Assets Depreciation .....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.17.H. Non-Medicare And Non-Medicaid Licensed Only

Salaries & Wages – R.N. .....Base
Salaries & Wages – L.P.N. .....Base
Salaries & Wages – Aides & Orderlies.....Base

Employee Benefits.....Base
Payroll Taxes.....Base
Nursing Supplies.....Base
Contracted Services.....Base
In-service Training.....Support
Education.....Support
Salaries & Wages – In-service Training.....Support
Employee Benefits – In-service Training.....Support
Payroll Taxes – In-service Training.....Support
Minor Equipment – Less Than $5,000.....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
Direct Allocation – Fixed Assets Depreciation.....Plant 1
Direct Allocation – Moveable Equipment Depreciation.....Plant 2
Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.17.I. Non-LTC Nursing Services

Salaries & Wages – R.N.....Base
Salaries & Wages – L.P.N.....Base
Salaries & Wages – Aides & Orderlies.....Base
Employee Benefits.....Base
Payroll Taxes.....Base
Nursing Supplies.....Base
Contracted Services.....Base
In-service Training.....Support
Education.....Support
Minor Equipment – Less Than $5,000.....Support
Minor Equipment – More Than $5,000.....Plant 2
Equipment Rental – Less Than 12 Months.....Support
Equipment Rental – More Than 12 Months.....Plant 2
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Direct Allocation – Interest & Property Taxes.....Plant 3
Miscellaneous – Base.....Base
Miscellaneous – Support.....Support

14.18 Reimbursable/Non-Reimbursable Cost Centers

14.18.A. Non-Available Beds

Medicaid Non-Available Beds.....Non-Reimbursable

14.18.B. Nurse Aide Training & Testing - LTC

Nurse Aide Training & Testing.....Pass-Through

14.18.C. Special Dietary

Salaries & Wages – Special Dietary .....Base
Employee Benefits.....Base
Workers' Compensation .....Base
Payroll Taxes .....Base
Contracted Services – Base .....Base
Contracted Services – Support.....Support
Contracted Services – Base/Support.....Base/Support
In-service Training .....Support
Education .....Support
Minor Equipment – Less Than $5,000 .....Support
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Equipment Rental – More Than 12 Months .....Plant 2
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Direct Allocation – Moveable Equipment Depreciation .....Plant 2
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Repair & Maintenance.....Support
Raw Food .....Base
Dietary Supplies (Non-Ingested).....Base
Miscellaneous – Base.....Base
Miscellaneous – Support .....Support

14.18.D. Beauty & Barber Shop

Salaries .....Non-Reimbursable
Other .....Non-Reimbursable

14.18.E. Gift, Flower, Coffee Shop & Canteen

Salaries .....Non-Reimbursable
Other .....Non-Reimbursable

14.18.F. Physician's Private Office

Salaries .....Non-Reimbursable
Other .....Non-Reimbursable

14.18.G. Non-Paid Workers

Salaries .....Non-Reimbursable
Other .....Non-Reimbursable

14.18.H. Other

Other Salaries .....Non-Reimbursable
Other .....Non-Reimbursable

NURSING FACILITY LEVEL OF CARE DETERMINATION

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) is required to assess all individuals seeking Medicaid-funded long-term services and supports (LTSS) that require level of care eligibility to determine their functional need for those services. The determination is an essential component of eligibility for services provided in nursing facilities, the MI Choice Waiver Program, the Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link Home and Community Based Services (HCBS) Waiver Program. Policies contained herein apply equally and consistently to each of these programs except as noted.

MDHHS uses a standard assessment and process for all programs and services that require an individual meet the nursing facility level of care. Programs may not use any other assessment in place of the Level of Care Determination (LOCD) tool for this determination. The LOCD assures a consistent and reliable process for determining that individuals meet the functional eligibility requirements.

Providers may access the LOCD online in the Community Health Automated Medicaid Processing System (CHAMPS) through the MILogin application. (Refer to the Directory Appendix for website information.) LOCD assessment data is entered and processed in CHAMPS.

The LOCD is a "point in time" assessment; that is, it determines the individual's functional eligibility at the time of the assessment. MDHHS assumes that beneficiaries will maintain functional eligibility until they are determined otherwise through a reassessment or the LOCD's End Date. An LOCD is an in-person meeting between the qualified and licensed health professional and the individual seeking functional eligibility.

SECTION 2 – ELIGIBILITY REQUIREMENTS

Individuals seeking Medicaid-funded services from nursing facilities, MI Choice Waiver Program, PACE, or the MI Health Link HCBS Waiver Program must meet eligibility criteria. These criteria must be met before Medicaid payment is made for services rendered. Each beneficiary must be eligible for Medicaid services, demonstrate a need for nursing facility level of care, and meet all additional program-specific requirements. Medicaid reimbursement for covered services is only appropriate when both financial and functional eligibility have been established, and the individual meets other program-specific eligibility criteria.

2.1 BASIC MEDICAID ELIGIBILITY

Eligibility for Medicaid is determined by a variety of factors including, but not limited to, financial rules, age, health status, state residency and citizenship status. Providers are instructed to refer individuals who are not yet Medicaid eligible to a local MDHHS office or the MDHHS website for assistance. (Refer to the Directory Appendix for website information.)

2.2 NEED FOR NURSING FACILITY LEVEL OF CARE

An individual's need for nursing facility level of care is determined through the Nursing Facility Level of Care Determination (LOCD) assessment tool. The LOCD is a scientifically-validated and reliability-tested tool utilized during initial application and program eligibility redeterminations. This chapter describes the criteria and processes for administering the LOCD.

2.3 PROGRAM SPECIFIED ELIGIBILITY REQUIREMENTS

In addition to meeting Medicaid financial and functional eligibility requirements, individuals must also meet all program specific requirements before they can be determined eligible for that program. (Refer to the Nursing Facility Coverages, the MI Choice Waiver, the Program of All-Inclusive Care for the Elderly, and the MI Health Link chapters or to provider contracts for specific program requirements.) This chapter applies only to the LOCD process and is not intended to replace program-specific requirements.

SECTION 3 – NURSING FACILITY LEVEL OF CARE DETERMINATION PROCESS

3.1 LOCD ASSESSMENT REQUIREMENT FOR REIMBURSEMENT

The LOCD must be conducted prior to or on the day of an individual's admission to a nursing facility or enrollment in MI Choice Waiver Program, PACE, or MI Health Link HCBS Waiver Program to ensure reimbursement for a Medicaid eligible beneficiary. The LOCD must be conducted in person by a qualified and licensed health professional. The qualified and licensed health professional conducting the LOCD or a designated employee of the organization must enter the assessment findings online in the CHAMPS system. Except where otherwise noted, only LOCDs entered in CHAMPS are considered valid for establishing functional eligibility.

The LOCD is considered payable when all the following conditions are met:

- the beneficiary meets LOCD criteria;
- the LOCD is entered online in CHAMPS;
- the LOCD is active on the date of service (meaning the date of service is on or after the LOCD Start Date and before the LOCD End Date); and
- the beneficiary is receiving LTSS and meets all program-specific eligibility criteria.

3.2 PERSONS AUTHORIZED TO CONDUCT THE LOCD

A qualified and licensed health professional must be a physician, registered nurse, licensed practical nurse, licensed social worker (Limited License Bachelor of Social Work, Limited License Master Social Worker, Licensed Bachelor Social Worker, or Licensed Master Social Worker), physician's assistant, nurse practitioner, licensed psychologist, physical therapist, respiratory therapist, occupational therapist or speech therapist. Once the LOCD is completed by a qualified and licensed health professional, a clinical or non-clinical staff person may enter the LOCD information in CHAMPS. When the LOCD data are entered, CHAMPS applies the MDHHS algorithm to determine eligibility.

3.3 INITIAL LOCD ASSESSMENT

The LOCD must be conducted in person by a qualified and licensed health professional (as defined in the Persons Authorized to Conduct the LOCD subsection) before the provider is eligible for Medicaid reimbursement for services rendered to the beneficiary. The LOCD must be conducted prior to or on the day of admission or enrollment. The LOCD assessment findings for all LOCDs conducted, including Door 0 (zero), which indicate the individual does not meet LOCD criteria must be entered online in CHAMPS. (LOCD Doors are described in the Nursing Facility Level of Care Determination Criteria section.)

All LOCD determinations must be entered in CHAMPS. This is regardless of whether the individual or beneficiary meets LOCD criteria.

The provider may conduct LOCDs for individuals without Medicaid eligibility and enter the LOCD in CHAMPS prior to Medicaid eligibility being established. NOTE: Medicaid reimbursement for covered services is only appropriate when both financial and functional eligibility have been established, and the individual meets other program-specific eligibility criteria.

3.4 Adoption of an Existing LOCD by Another Provider

The LOCD is associated with the beneficiary, rather than the provider serving the beneficiary. Therefore, if a beneficiary is seeking admission to or enrollment in a program and has a current LOCD in CHAMPS, the provider may adopt that LOCD to confirm functional eligibility. When adopting a current LOCD, the provider must print out the computer-generated FOC from that LOCD record and complete the form with proper signatures and date. A qualified and licensed health professional from the admitting or enrolling provider must sign and date the CHAMPS-generated FOC from the adopted LOCD record. The FOC must also be signed by the beneficiary or their legal representative.

The provider may also choose to conduct a new LOCD. A new LOCD must be conducted if the current LOCD is no longer an accurate representation of the beneficiary's current functional status.

3.5 LOCD Start and End Dates

All LOCDs must be entered in CHAMPS within 14 calendar days from the date the qualified and licensed health professional conducted the in person LOCD. Functional eligibility is valid for 365 days from the conducted date unless the provider conducts a new LOCD because a beneficiary had a significant change of condition. If a subsequent LOCD is conducted prior to the LOCD End Date and confirms the individual meets LOCD criteria, the new LOCD will have a 365-day end-date. Providers should refer to their specific program policies and procedures regarding the definition of a significant change of condition.

Each beneficiary must have a current LOCD in CHAMPS to establish eligibility for Medicaid reimbursement. The provider is responsible for:

- confirming that a current LOCD demonstrating eligibility is in CHAMPS;
- monitoring the beneficiary's LOCD End Date to avoid an interruption in functional eligibility; and
- conducting another LOCD for the beneficiary prior to the current LOCD End Date or when there is a significant change of condition.

The LOCD Start Date will be the date the LOCD was conducted if the LOCD is entered in CHAMPS within 14 days of the conducted date. If the LOCD is entered in CHAMPS more than 14 days from the date the LOCD was conducted, CHAMPS will set the LOCD Start Date as the date the LOCD was entered in the system. The End Date of an LOCD will be 365 days from the date the LOCD was conducted. LOCDs are payable from the Start Date through the End Date. (Refer to the Nursing Facility Level of Care Determination Criteria section for an explanation of each Door.)

3.6 Verification Review of LOCD [Change Made 4/1/2025]

The purpose of the verification review (LOCD-VR) is to determine if the LOCD was conducted properly according to policy and resulted in the correct determination of eligibility. A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee. CHAMPS will randomly select a statistically significant sample of LOCDs entered in the system. Upon submission of the LOCD in the system, CHAMPS will

immediately notify the provider if the LOCD was selected for review with a pop-up message. The provider is required to submit all relevant documentation used to support the LOCD including, but not limited to, observation notes, assessment reports, physician orders or notes, caregiver reports, cognitive test results, time studies, nursing or case management notes, intervention reports, or evidence of other medical or community services provided. The related CHAMPS LOCD Application ID must be indicated on all documents for tracking purposes. Documents must be uploaded electronically in CHAMPS within four calendar days **(revised per bulletin MMP 24-53)** of the LOCD being selected for verification review in CHAMPS.

MDHHS or its designee will review the documentation furnished by the provider and make a determination within two business days of receiving the required documentation. Upon conclusion of the review, MDHHS or its designee will inform the provider of the results of the review in CHAMPS. When an LOCD is selected for review, the determination of eligibility is not complete until MDHHS or its designee notifies the provider of the results of the verification review.

When the individual is found to not meet LOCD criteria, MDHHS or its designee will provide to the individual an Adequate Action Notice including appeal rights per Medicaid policy. Services provided to the individual during the verification review process will not be eligible for Medicaid reimbursement.

3.7 Ongoing Functional Eligibility

Medicaid LTSS providers are required to ensure the individual continues to meet eligibility requirements on an ongoing basis. The functional eligibility that is assessed by the LOCD is one of the eligibility requirements. Therefore, Medicaid LTSS providers must ensure that individuals meet LOCD criteria on an ongoing basis. The LTSS provider is responsible for conducting a new LOCD if there is a significant change in the beneficiary's condition. When a provider possesses information that a beneficiary may no longer meet eligibility, the provider must conduct an in person reassessment. Such information may come in the form of progress notes, routine assessments, staff observations, or any other documentation that might call into question the continued functional eligibility of the beneficiary.

3.8 Passive Redetermination of Functional Eligibility [Changes Made 4/1/2025]

Providers are responsible for reassessing LOCD eligibility prior to the End Date of the current LOCD or when there is a significant change in the beneficiary's condition. The Minimum Data Set (MDS) and interRAI Home Care Assessment System (iHC) contain items that correspond to the items in the LOCD. Under certain conditions, MDHHS will use a passive redetermination process based upon information from the beneficiary's most recent assessment and program enrollment or admission.

When this data is available, MDHHS will apply an algorithm that uses the common assessment items to allow CHAMPS to generate a new LOCD for the beneficiary. **(revised 4/1/2025)**

(text deleted 4/1/2025) An LOCD generated by CHAMPS can be adopted by all LTSS programs.

3.8.A. LOCD Doors Addressed by Passive Assessment [Change Made 4/1/2025]

The correspondence between MDS and iHC assessment items and LOCD items is extensive but not complete. Therefore, the algorithm used for the passive

redetermination process is not able to verify eligibility through all LOCD doors. The passive redetermination process may confirm LOCD eligibility as follows:

Door 1: The passive redetermination process can confirm all criteria.

Door 2: The passive redetermination process can confirm all criteria.

Door 3: The passive redetermination process can confirm criteria from the MDS (nursing facilities). The passive redetermination process cannot confirm criteria from the iHC (MI Choice).

Door 4: The passive redetermination process cannot confirm criteria.

Door 5: The passive redetermination process cannot confirm the criteria. **(revised per bulletin MMP 24-53)**

Door 6: The passive redetermination process can confirm criteria from the MDS (nursing facilities). The passive redetermination process can partially confirm criteria from the iHC (MI Choice).

Door 7: The passive redetermination process cannot confirm the criteria.

Door 8: The passive redetermination process cannot confirm the criteria.

3.8.B. Passive Redetermination Process

The initial LOCD for a beneficiary must be conducted in an in-person meeting by a qualified and licensed health professional. When a current LOCD exists for a beneficiary, MDHHS will use the passive redetermination process to allow CHAMPS to generate a new LOCD for the beneficiary. The amount of time from the provider conducting an assessment to MDHHS having access to the assessment data varies, affecting when the passive redetermination process will be applied.

When this process confirms continued functional eligibility, the Start Date of the CHAMPS-generated LOCD will be the date of the MDS or iHC assessment. CHAMPS will set the End Date at 365 days from the newly established Start Date. This process will repeat with each new MDS or iHC when the passive redetermination process confirms the beneficiary meets LOCD criteria and allows CHAMPS to generate a new LOCD.

When a beneficiary is currently eligible through a door that the passive redetermination process cannot confirm, the LOCD will be bypassed from the passive redetermination process and the current End Date will remain in effect.

The passive redetermination process will not determine ineligibility. If an individual previously met LOCD criteria through a Door the passive redetermination process can assess, and the process cannot establish eligibility from the most recent MDS or iHC, CHAMPS will issue a notice to the provider. Additionally, CHAMPS will generate a new LOCD using Door 87 with a Start Date equal to the date the passive redetermination process was applied to the MDS or iHC assessment. Door 87 LOCD will have an End

Date of 45 days from the Door 87 Start Date, or the End Date of the previous LOCD, whichever is earlier.

The provider must conduct a face-to-face LOCD before the Door 87 End Date to confirm the beneficiary continues to meet LOCD criteria. If the provider does not conduct a face-to-face LOCD before the Door 87 End Date, the provider will not be eligible for Medicaid reimbursement. Door 87 is not sufficient basis for issuing an Adverse Action Notice to the beneficiary. An Adverse Action Notice must be based upon a face-to-face LOCD.

3.8.C. Passive Redetermination Decisions

If the face-to-face LOCD results are:	And the Passive Redetermination results are:	Then the LOCD results are as follows:
Eligible through a Door assessed by Passive Redetermination e.g. Door 1	Confirmed by Passive Redetermination e.g. confirm Door 1	New LOCD created with End Date 365 days from date of the MDS or iHC assessment.
Eligible through a Door not assessed by Passive Redetermination e.g. Door 4	Passive Determination is not applied	No change to existing LOCD or its End Date.
Eligible through any Door e.g. Door 7	Eligible through a different Door e.g. Door 2	New LOCD created with the Passive Redetermination Door and an End Date 365 days from the date of the MDS or iHC assessment.
Eligible through a Door assessed by Passive Redetermination e.g. Door 2	Passive Redetermination does not determine eligibility through any Door	LOCD Door 87 created with an End Date of 45 days from the date the passive redetermination ran.

Note: For the passive redetermination process to occur, a current LOCD must be in CHAMPS and the MDS or iHC must be conducted prior to the End Date of the LOCD.

3.8.D. Need to Conduct a New LOCD

For the Doors that the passive determination is unable to assess, the provider must conduct an in-person LOCD prior to the current LOCD End Date. The provider must conduct a new LOCD prior to the End Date and enter it in CHAMPS within 14 days of the conducted date.

When the passive redetermination applies but the process cannot confirm eligibility based upon MDS or iHC assessment data, CHAMPS will create a LOCD Door 87 with an End Date 45 days from the date that record is loaded in CHAMPS, or until the current End Date, whichever is earlier. When the passive redetermination process continuously confirms that the beneficiary meets LOCD criteria, it is possible that the beneficiary will not require another in-person LOCD because the passive redetermination process

confirms LOCD eligibility and creates a new LOCD with a new 365-day End Date. In addition, providers must conduct an in-person LOCD when there is a significant change in the beneficiary's condition, as defined by the program.

SECTION 4 – NURSING FACILITY LEVEL OF CARE DETERMINATION CRITERIA

The Michigan Nursing Facility Level of Care Determination criteria includes seven domains of need, called Doors. The Doors include: (1) Activities of Daily Living; (2) Cognitive Performance; (3) Physician Involvement; (4) Treatments and Conditions; (5) Skilled Rehabilitation Therapies; (6) Behaviors; and (7) Service Dependency. The Doors and the assessment items are listed below. Guidance on administering the LOCD, including definitions and methods, is provided in the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines.

The LOCD should be an accurate reflection of an individual's current functional status. This information is gathered in an in-person meeting by speaking to the individual and those who know the individual well, observing the individual's activities, and reviewing an individual's medical documentation. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines on the MDHHS website for more information. (Refer to the Directory Appendix for website information.)

4.1 DOOR 1: ACTIVITIES OF DAILY LIVING

Door 1 assesses four ADLs: (1) Bed Mobility; (2) Transfers; (3) Toilet Use; and (4) Eating.

4.2 DOOR 2: COGNITIVE PERFORMANCE

Door 2 assesses short-term memory, cognitive skills for daily decision-making and making self-understood.

4.3 DOOR 3: PHYSICIAN INVOLVEMENT

Door 3 assesses the frequency of physician visits and physician order changes.

4.4 DOOR 4: TREATMENTS AND CONDITIONS

Door 4 assesses a set of nine treatments and conditions that may be a predictor of potential frailty or increased health risk. The treatments and conditions include: Stage 3-4 Pressure Sores; Intravenous or Parenteral Feeding; Intravenous Medications; End-stage Care; Daily Tracheostomy Care, Daily Respiratory Care, Daily Suctioning; Pneumonia within the Last 14 Days; Daily Oxygen Therapy; Daily Insulin with Two Order Changes in the Last 14 Days; and Peritoneal or Hemodialysis.

4.5 DOOR 5: SKILLED REHABILITATION THERAPIES

Door 5 assesses the presence of rehabilitation interventions, including physical therapy, occupational therapy, and speech therapy.

4.6 DOOR 6: BEHAVIOR

Door 6 assesses behavioral challenges. It includes five behavioral symptoms: wandering, verbal abuse, physical abuse, socially inappropriate or disruptive behavior, and resistance to care. Door 6 also assesses for the presence of delusions and hallucinations.

4.7 Door 7: Service Dependency

Door 7 applies to beneficiaries currently receiving other services and supports in nursing facilities, MI Choice, PACE, or the MI Health Link HCBS Waiver program. It assesses the beneficiary's dependence on services to maintain the current level of functioning and whether there are options for maintaining the level of functioning with services and supports available in the community.

4.8 Door 8: Frailty

MDHHS or its designee determined that the beneficiary is eligible for Medicaid LTSS services based upon the Frailty Criteria. Individuals who exhibit certain behaviors and treatment characteristics that indicate frailty may be admitted or enrolled to LTSS programs requiring an LOCD. The individual needs to trigger one element of this criteria to be considered for Frailty. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Exception Process on the MDHHS website for more information. (Refer to the Directory Appendix for website information.) For the MI Health Link program, the Frailty Criteria are applied by the Integrated Care Organization.

4.9 Door 0: Ineligible

The LOCD was conducted and the beneficiary did not meet the criteria for any of the doors. The beneficiary is not eligible for Medicaid LTSS services at this time. (Refer to the Individual Does Not Meet LOCD Criteria, Action Notices, and Appeal Rights section for additional information.)

4.10 Door 87: Eligible Pending In-Person Reassessment

The passive redetermination process could not confirm eligibility. The provider has 45 days from the date of the passive redetermination or until the current End Date, whichever is earlier, to conduct a new in-person assessment.

SECTION 5 – INFORMED CHOICE

Informed choice is important for the MDHHS admission or enrollment process for LTSS. It is essential that individuals and their legal representatives fully understand all available options for receiving Medicaid LTSS. When an individual meets LOCD criteria, they automatically meet the functional eligibility requirement for nursing facility care, MI Choice Waiver Program, PACE, and MI Health Link HCBS Waiver Program. The Freedom of Choice form confirms that these options and referral processes have been explained to the individual. All Medicaid-funded LTSS programs are required to make program information available to individuals at admission/enrollment, at an in-person reassessment, and upon request from the individual or their legal representative.

Program providers must explain all Medicaid LTSS options as well as other available LTSS to the individual in a language the individual understands, as well as culturally and linguistically appropriate. It is important that individuals understand their options and that they have ongoing access to information about all settings and programs. As the functional ability of the individual may change over time and program options may change, it is important to continue to update their options and discharge plan.

5.1 FREEDOM OF CHOICE FORM

A properly completed Freedom of Choice (FOC) form documents the individual's choice of where to receive LTSS. It is required that all LTSS programs use this form to confirm the individual was made aware of their choices and to document the individual's preference. It is critical that individuals understand their options and have ongoing access to information about settings and programs. This requires providing the information using methods that are effective for the individual and in the individual's primary language. The individual (or their legal representative) must be informed of Medicaid LTSS available through the MI Choice Waiver Program, nursing facilities, PACE, and MI Health Link HCBS Waiver Program. An explanation regarding each program must be provided in a manner and using language that the individual understands. A hard copy of the form must be printed so signatures can be provided, and the signed form retained in the beneficiary's case record. The FOC form must be completed each time the beneficiary changes programs or providers, whether a new LOCD is conducted or not.

A CHAMPS-generated FOC form is automatically created online (and available to print) for every individual for whom an online LOCD was completed, regardless of the individual's determination of eligibility.

When adopting a current LOCD, the provider must print out the computer-generated FOC from that LOCD record and complete the form with proper signatures and date. A qualified and licensed health professional from the admitting or enrolling provider must sign and date the CHAMPS-generated FOC for the adopted LOCD record. The FOC must also be signed by the individual or their legal representative.

The information in Section I of the FOC is automatically populated by CHAMPS when the LOCD is entered. The individual's name, date of birth, conducted date of the LOCD, eligibility status, and, if determined eligible, the door through which the individual qualified is entered by the system. If the individual is found ineligible, a Door 0 will populate. The system also enters the provider's information and the date the LOCD was created. The qualified and licensed health professional who conducted or adopted the LOCD must sign, provide their title, and date the FOC under Section I. If using an FOC form not generated by CHAMPS, the provider must complete the appropriate fields in Section 1 and sign and date the form.

Section II of the FOC provides a list of LTSS options available to individuals who meet LOCD criteria, including nursing facility care, MI Choice Waiver Program, PACE, or MI Health Link HCBS Waiver Program. Individuals must also be informed of service options that do not require nursing facility level of care, including Home Health, Home Help State Plan services, and other services available locally that are not Medicaid-funded.

Section III of the FOC is completed when an individual does not meet the LOCD criteria. The individual, or their legal representative, must sign their name and provide the date they were notified of their LOCD ineligibility and appeal rights. Appeal rights must be provided according to Michigan Medicaid policy.

The form is completed when the above steps have been taken and it is signed and dated by the qualified and licensed health professional who conducted the LOCD and by the individual or their legal representative. The completed FOC form must be maintained in the individual's record and provided to the individual or their legal representative upon request. A copy of the completed FOC form for non-qualifying individuals must be retained for at least three years.

SECTION 6 – INDIVIDUAL DOES NOT MEET LOCD CRITERIA, ACTION NOTICES, AND APPEAL RIGHTS

If an individual does not meet LOCD criteria for Doors 1 through 7, the provider must provide notice to the individual. The individual may request a Secondary Review from MDHHS or its third-party designee and request a Medicaid Fair Hearing before an Administrative Law Judge.

6.1 ISSUING AN ADVERSE ACTION NOTICE

When a qualified and licensed health professional determines that an individual does not qualify for nursing facility level of care services based on the online LOCD, and the provider does not contact the MDHHS designee to request a Secondary Review, the provider must issue an adverse action notice to the individual or their legal representative. The provider must also offer the individual referral information about other services that may meet the individual's needs.

6.2 ADEQUATE ACTION NOTICE

For individuals who are not currently receiving LTSS in a program or setting that requires an LOCD, an adequate action notice is provided when the initial LOCD determines the individual does not meet LOCD criteria. The adequate action notice must include all the language in the sample adequate action notices for LTSS available on the MDHHS LOCD website. (Refer to the Directory Appendix for website information.)

6.3 ADVANCE ACTION NOTICE

The advance action notice is applicable to beneficiaries who met their initial LOCD, but based upon a significant change in condition, did not meet their subsequent LOCD. The advance action notice must include all of the language in the sample advance action notices for LTSS available on the MDHHS LOCD website. (Refer to the Directory Appendix for website information.)

When a current LTSS beneficiary is determined to not meet LOCD criteria, the provider must follow program-specific procedures for the provision of notice to the beneficiary.

6.4 LOCD SECONDARY REVIEW

The provider or the individual (or their legal representative) may request an LOCD Secondary Review. This review is completed by MDHHS or its designee to ensure full consideration of LOCD eligibility options. The Secondary Review is available only when an LOCD is entered in CHAMPS and results in a Door 0, indicating ineligibility. The review is a secondary review of documentation for all LOCD Doors, including Door 8.

The LOCD Secondary Review Process is conducted as follows:

- A Secondary Review may be initiated by the provider, individual or their legal representative after the qualified and licensed health professional issues an adverse action notice based on a finding of ineligibility. The provider, individual or their legal representative may request a Secondary

Review from MDHHS or its designee. The individual will have three business days to make a request following written notice of the adverse action.

- In the action notice, the provider who conducted the ineligible LOCD must provide the individual with information on how to timely request a Secondary Review following an ineligible LOCD.
- Following the individual's request for review, the MDHHS designee will contact the provider who conducted the LOCD and inform them to upload documentation in CHAMPS for review.
- The provider who conducted the LOCD will upload the relevant documentation in CHAMPS within one business day of being notified to do so.
- The MDHHS designee will review the documentation, obtain information from the individual or their legal representative, if requested, and notify the provider and the individual or their legal representative of the decision.
- If the Secondary Review determines that the individual is eligible, MDHHS or its designee will contact the provider and the individual or their legal representative.
- If the Secondary Review determines that the individual is ineligible, MDHHS or its designee will issue an adverse action notice and inform the individual of their appeal rights.
- MDHHS or its designee will enter the appropriate LOCD in CHAMPS.

6.5 Appeal Rights and Medicaid Fair Hearing

When an individual is determined ineligible for services and an appeal is requested, it is an adverse action for the individual. If the individual or their legal representative disagrees with the denial, they may request an administrative hearing.

The Michigan Office of Administrative Hearings and Rules (MOAHR) Administrative Hearings Pamphlet explains the process by which an administrative hearing and a preliminary conference are brought to completion. The pamphlet is available for review on the MDHHS website. (Refer to the Directory Appendix for website information.) Both a provider representative and a MDHHS Long Term Care Policy Section representative must be present at the hearing.

When a current LTSS beneficiary is determined to not meet LOCD criteria, the provider must follow program-specific procedures for the provision of notice to the beneficiary.

When a beneficiary is determined to no longer be eligible for Medicaid-funded services and an appeal is requested, Medicaid will continue to pay for services if the beneficiary appeals within required program timeframes. If the beneficiary does not appeal the decision, the provider is eligible for Medicaid-reimbursement through the effective date of the advanced action notice, or the date in which the beneficiary stopped receiving services, whichever is first. When the beneficiary appeals the decision in compliance with MDHHS policy, MDHHS will reimburse the provider for services throughout the appeal process. If the beneficiary's appeal is denied, MDHHS will reimburse the provider for up to 30 days from the date of issuance of the hearing decision and order.

PHARMACY

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SECTION 1 – GENERAL INFORMATION [CHANGE MADE 4/1/2025]

Michigan Department of Health and Human Services (MDHHS) administers the fee-for-service (FFS) programs for Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), and Maternity Outpatient Medical Services (MOMS). This chapter, the Michigan Pharmaceutical Product List (MPPL), and the Michigan Preferred Drug List (PDL)/Single PDL comprise program policies and explain coverage and reimbursement for the services dispensed and billed by enrolled pharmacies.

Throughout this chapter, the terms Medicaid and MDHHS are used to refer to Michigan Medicaid FFS, Healthy Michigan Plan, CSHCS, and MOMS programs and to Plan First Family Planning benefit plans unless otherwise noted. **(revised 4/1/2025)**

1.1 MDHHS PHARMACY BENEFITS MANAGER AND OTHER VENDOR CONTRACTORS

MDHHS retains all decisions for policy, coverage, and reimbursement, and contracts with a pharmacy benefits manager (PBM). PBM services provided include pharmacy claims payment (paper and electronic), claims instruction, prior authorization (PA), prospective drug utilization, retrospective drug utilization, clinical consultation, provider information lines, and Maximum Allowable Cost (MAC) rate setting. (Refer to the Directory Appendix for PBM contact information.)

The PBM website contains the:

- Pharmacy Claims Processing Manual for Michigan Medicaid
- Michigan Pharmaceutical Product List (MPPL)
- Michigan Preferred Drug List (PDL)/Single PDL
- Drug Utilization Review (DUR) Meeting Notices
- Dose Optimization Program
- Pharmacy and Therapeutics (P&T) Committee Meeting Notices
- Pharmacy Forms
- Maintenance Drug List

Pharmacies may call the PBM for questions or concerns. Beneficiaries may call the PBM Beneficiary Helpline. (Refer to the Directory Appendix for contact information.)

MDHHS contracts with other vendors to perform financial, program or provider audits on behalf of the State of Michigan. (Refer to the Provider Resources portion of the Directory Appendix for additional information.)

1.2 DEFINITIONS

The following definitions have specific meaning in the Pharmacy program:

Brand-Name Drug	A single-source drug, a cross-licensed drug or an innovator drug for which a lower-cost generic equivalent is available.

Compounded Prescription	The combination of two or more ingredients extemporaneously mixed in usually accepted therapeutic doses. This requires the pharmacist's skill in weighing, measuring, levigating, etc., at the time of dispensing. The allowable compounding fee applies to the preparation of an individual prescription. It does not apply to prescriptions dispensed from a previously prepared stock supply (i.e., premaking a special lotion, cream, or ointment in gallons or pounds).
Dispensing Fee	Payment for filling a prescription and all related services performed by a pharmacist.
Drug Efficacy Study Implementation (DESI) Drugs	FDA designations related to "substantial evidence" of effectiveness. These products are also known as proposed less than effective.
Drug Rebate Program	Administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations. It was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and requires drug manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the U.S. Department of Health & Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. To receive rebates, States must identify the drugs by their national drug code.
Drug Utilization Review (DUR)	A process designed to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical outcomes.
Drug Utilization Review Board (DUR Board)	An advisory board to the State's Medicaid Program that includes physicians and pharmacists.
Fraud	Deliberate, intentional, and willful act with the specific purpose of deceiving MDHHS with respect to any material fact, condition, or circumstance affecting eligibility or need.
Generic Drug	Refers to a nonproprietary drug or class of drugs. The generic name refers to the official chemical composition of the drug as published in the latest edition of a nationally recognized pharmacopoeia or drug compendium. Generics do not refer to a particular brand name product.
Labeler	Any firm that manufactures (including repackers or relabelers) or distributes (under its own name) the drug.
Legend Drug	A drug bearing the statement: "Caution – Federal Law Prohibits Dispensing without a Prescription."
Long Term Care Pharmacy	Refers to pharmacies specializing in provision of drugs and services in an institutional setting such as a nursing facility, medical care facility or hospital long term care unit.
Maximum Allowable Cost (MAC)	The maximum cost allowed by MDHHS for certain multiple source brands, generics, cross-licensed drugs and sometimes for sole-source drugs or classes.
Multiple Source Drug (Multi-Source)	A drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.
National Average Drug Acquisition Cost (NADAC)	Pricing benchmark based on a nationwide survey of retail community pharmacy covered outpatient drug prices.
National Council for Prescription Drug Programs (NCPDP)	Develops standards for electronic pharmacy transactions (Point of Sale claims transactions).

National Drug Code (NDC)	The 11-digit code assigned to all prescription and over-the-counter products by the labeler/manufacturer of the product under Food and Drug Administration (FDA) regulations.
Out of State Pharmacy	An entity not housed within the state of Michigan but registered by the Michigan Board of Pharmacy. An Out of State Pharmacist is required to be licensed in the state the pharmacy is located in.
Over-the-Counter (OTC) Drug	A drug that can normally be purchased without a prescription, although it may require a prescription if covered by Medicaid.
Pharmacist	A person licensed under Michigan statutes to provide services within the scope of pharmacy practice.
Pharmacy	An entity registered by the Michigan Board of Pharmacy.
Pharmacy and Therapeutics (P&T) Committee	An advisory committee to MDHHS on issues affecting prescription drug coverage for its various health care programs. The committee recommends guidelines for prescription drugs covered in its various health care programs.
Point of Sale (POS)	Real-time on-line adjudication of pharmacy claims to the PBM. Point of-Sale provides participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing information, guidelines for drug use, and dispensing fees.
Prescribed Drug	A drug, either legend or over-the-counter, that is ordered by a prescriber to be used by a patient to treat a disease or condition.
Prescriptions Not Picked Up	Retail prescriptions filled but not dispensed or picked up by the beneficiary or their representative.
Prospective Drug Utilization Review (ProDUR)	Detection, evaluation, and counseling components of pre-dispensing drug therapy screening. ProDUR is required at the point of sale before each prescription is delivered to a Medicaid beneficiary. ProDUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement of Medicaid participation.
Retrospective Drug Utilization Review (RetroDUR)	Program that analyzes and interprets patterns of prescribing and dispensing beneficiary drug usage through periodic examinations of claims data to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.
Tamper Resistant Prescription Pad	A tamper resistant prescription pad must contain all three of the following characteristics: ▪ Prevent unauthorized copying of a completed or blank prescription form. ▪ Prevent the erasure or modification of information written on the prescription by the prescriber. ▪ Prevent the use of a counterfeit prescription form.
Wholesale Acquisition Cost (WAC)	The list price determined by a manufacturer for a pharmaceutical sold by a manufacturer to a wholesaler.

1.3 Children's Special Health Care Services

Pharmacy coverage for beneficiaries who only have CSHCS coverage is limited to those pharmaceutical products that are required for the treatment of the CSHCS qualifying diagnosis. The beneficiary's CSHCS qualifying diagnosis is listed on their eligibility letter by ICD code. Pharmacies may not bill for

pharmaceutical products not required for the treatment of the CSHCS qualifying diagnosis. Also, the MPPL specifies other coverages unique to this program.

1.4 Place of Service

Coverage and payment policies for products dispensed in the settings listed below are not contained in this chapter or the MPPL. Healthcare providers should refer to the provider-specific chapter for Hospital, Practitioner, Nursing Facility, or Laboratory in this manual for these services:

- Physician's office or clinic: Injectable products used in physician offices or clinics are reimbursed to the healthcare provider administering the drug, not a pharmacy. If a pharmacy sells injectable products to a physician or clinic, a pharmacy must obtain payment directly from the purchasing provider and not MDHHS. Injectable products are not to be dispensed to the beneficiary for the purpose of administration at the physician's office.

  Exception: Beneficiaries with a Benefit Plan ID of NH (Nursing Home) can receive injectable drugs as a pharmacy benefit due to the relationship between the nursing facility and its contracted providers.
- Inpatient hospital.
- Mental health, hospital long term care, and medical care facilities with in-house pharmacies.
- Laboratory.

1.5 Outpatient Hospital

Outpatient hospitals with pharmacies enrolled with MDHHS as pharmacy providers must bill for take-home pharmaceutical products in compliance with policies of this chapter and the MPPL. Such services cannot be billed under the outpatient hospital's NPI number.

Injectable drugs and single doses given on the premises, including products used in conjunction with lab, radiology, and other medical procedures, must be billed using the outpatient hospital's NPI number, not the pharmacy's NPI number.

1.6 Hospice

Services, including drugs and nutritional supplements related to a beneficiary's terminal illness, are provided by the hospice (Benefit Plan ID of Hospice). The hospice reimburses pharmacies for these services. Coverage, payment amounts, and billing procedures of the particular hospice must be followed. To confirm that a product is not related to the terminal illness, the pharmacist must contact the hospice regarding coverage before billing. A pharmacy must not bill MDHHS for prescription services related to the terminal illness.

The MDHHS PBM messages back to the pharmacy when claims are submitted for beneficiaries with a Benefit Plan ID of Hospice. It is the pharmacy's responsibility to assure that the claim submitted is not related to the beneficiary's terminal illness. If billings contrary to this policy are found in post-payment review, MDHHS will recover inappropriate payment.

1.6.A. Exception for Selected HIV Drugs

MDHHS separately reimburses a pharmacy for selected HIV drugs that the beneficiary had previously used to prevent the terminal illness. These HIV drugs include Protease Inhibitors, Nucleoside/-tide Reverse Transcriptase Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, even though the product is related to the terminal illness.

1.6.B. Products Not Related to the Terminal Illness

Covered drug products not related to the terminal illness may be separately billed by the pharmacy. For example: A hospice beneficiary has leukemia and a lifelong condition of diabetes. Products related to the diabetes can be separately billed by a pharmacy provider.

1.7 Medicaid Health Plans

Providers should verify eligibility to determine if the beneficiary is enrolled in a MHP (Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC) for the DOS. (Refer to the Beneficiary Eligibility chapter for additional information.)

Coverage criteria (including PA) and reimbursement limits for members of MDHHS contracted Medicaid Health Plans (MHPs) may not follow the policies specified in this chapter applicable to FFS.

Each health plan enrolls its own providers and structures its own billing system. All plan providers are required to enroll/register in CHAMPS. Providers must contact the contracted plan for information regarding reimbursement issues.

Pharmacy Aspects of MHP: Quick Reference

Benefit Plan ID	CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC
Provider Enrollment	Pharmacies must follow the MHP procedures for enrollment to ensure payment.
Pharmaceutical Coverage	Approved MHP pharmaceutical products may differ from Medicaid FFS and CSHCS programs. The MHP Common Formulary establishes the minimum coverage requirements for drugs covered by health plans, as well as drug utilization management tools such as quantity limits, age and gender edits, prior authorization criteria, and step therapies. MHPs may be less restrictive, but not more restrictive, than the coverage parameters of the Common Formulary. Additional information is available on the MDHHS website. (Refer to the Directory Appendix for website information.) With the exception of products that are carved out, MHPs must have a process to approve provider requests for any prescribed medically appropriate product identified on the Michigan Pharmaceutical Product List (MPPL). (Refer to the Directory Appendix for website information.)
Copayment	Copayments may differ.
Payment and Billing	Payment levels and billing methods are set by the MHP, MDHHS.

Prior Authorization (PA)	Follow the MHP PA procedures.
Questions	For general managed care questions, call the MDHHS Provider Inquiry or Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) Contact the individual MHP for specific coverage questions.

1.7.A. Carve-Out Exceptions

Select drugs and classes may be carved-out from the respective health plan's reimbursement and paid Medicaid Fee For Service. (Refer to the PBM website listed in the Directory Appendix for a listing of these drug classes.)

Any services paid Fee For Service must follow appropriate guidelines for supporting documentation, including attending, billing, prescribing, referring, rendering and supervising provider requirements.

1.8 Intermediate Care Facility for Individuals with Intellectual Disabilities

Beneficiaries residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are identified by the Benefit Plan ID of ICF/IID. For Medicare/Medicaid dually-eligible beneficiaries, pharmacy services will be covered by Medicare Part D. Drugs not covered by Medicare Part D are included in the ICF/IID per diem rate.

1.9 Medicare Part D Benefit

The Medicare Modernization Act of 2003 provides a prescription drug benefit to Medicare beneficiaries. The benefit is commonly referred to as Medicare Part D. Dually enrolled Medicare/Medicaid beneficiaries must obtain all Part D covered drugs through their Medicare Part D Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD).

Drugs covered by Medicare Part D, but not included in the beneficiary's Medicare Part D Plan's formulary, will not be covered by Medicaid.

Medicaid does not cover Part D drugs for beneficiaries who are enrolled in Medicare Part A and/or Part B and elect to opt out of a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.)

Drugs excluded from coverage by Medicare Part D will not be covered by Medicaid, except for the following:

- Over-the-counter (OTC) drugs listed on the MPPL
- Over-the-counter agents used to promote smoking cessation

- Select group of vitamins and minerals prescribed at therapeutic doses for deficiency diagnoses that meet Medicaid coverage criteria

Questions concerning the Medicare Part D benefit must be directed to Medicare. (Refer to the Directory Appendix for contact information.)

SECTION 2 – PRESCRIBER REQUIREMENTS

All MDHHS-covered legend and over-the-counter drugs (OTCs), except condoms, require a prescription order by a licensed professional acting within their scope of practice as defined by state and federal laws, rules, and regulations.

Coverage of pharmaceutical products is based on limitations stated in this chapter, the MPPL, and medical necessity. Determination of medical necessity and appropriateness of service is the responsibility of the prescribing physician/provider (prescriber) within the scope of currently accepted medical practice and MDHHS limitations. Participating providers must observe applicable State and Federal laws, rules, regulations, and policies. Providers or designees of such providers who prescribe a controlled substance are required to check the Michigan Automated Prescription System (MAPS) for the beneficiary's 12-month prescription drug history before prescribing controlled substances. Documentation of the required MAPS check should be retained in accordance with the Medicaid record retention policy. Exemptions to this requirement include:

- Beneficiaries who are receiving cancer treatment or hospice/ palliative care in long-term care facilities described in 1396d of Title XIX or other facilities with a single pharmacy contract, and
- Prescriptions provided during declared natural disasters or emergency services. (Refer to the Directory Appendix for MAPS information.)

MDHHS may impose additional constraints to reduce misuse.

2.1 SCOPE OF PRACTICE

MDHHS only reimburses for products prescribed by a licensed prescriber that are within the prescriber's scope of currently accepted medical practice and MDHHS limitations.

2.2 PRESCRIBER IDENTIFICATION [CHANGE MADE 4/1/2025]

Pharmacy providers must provide the individual prescriber's National Provider Identifier (NPI) on the submitted claim. MDHHS will deny pharmacy claims where the prescriber is not enrolled in CHAMPS. Exceptions to this in compliance with MDHHS policy include:

- Prescriber enrollment in another state Medicaid program has been validated.
- Prescription is being provided during a declared natural disaster or emergency services. **(text added per bulletin MMP 25-01)**

Refer to the General Information for Providers chapter and the Practitioner chapter for additional information.

2.3 SANCTIONED PRESCRIBERS

MDHHS does not reimburse for pharmaceuticals prescribed by providers sanctioned by the Federal Government, the State of Michigan, or for prescribers having a limited, expired (lapsed), or revoked license. A list of sanctioned providers is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4 Other Pertinent Sections

Prescribers should refer to other pertinent sections in this chapter for policies and procedures related to Drug Utilization Review, Prior Authorization, and the MPPL.

SECTION 3 – PHARMACY REQUIREMENTS

3.1 COMPLIANCE WITH APPLICABLE STATE, FEDERAL, AND MDHHS PROVISIONS

A provider who complies with all licensing and regulation laws applicable to the practice of pharmacy in Michigan may enroll as a Medicaid provider. Applicable State and Federal laws, rules, regulations, and policies must be observed by participating pharmacies. MDHHS does not enroll dispensing physicians as Medicaid providers for pharmacy services. (Refer to the General Information for Providers Chapter of this manual for additional information.)

3.2 ENROLLMENT

Pharmacy enrollment is processed through CHAMPS. Refer to the General Information for Providers Chapter, Provider Enrollment section, for additional information.

SECTION 4 – COUNSELING REQUIREMENTS

Pharmacies must follow the counseling requirements mandated in State and Federal statutes and regulations. These requirements do not apply to drugs dispensed in nursing facilities that are in compliance with the drug regimen review procedures specified by the licensing authority.

4.1 OFFER TO DISCUSS

For every new prescription presented by the beneficiary, the pharmacy's representative must offer the beneficiary the opportunity to discuss/receive counseling from the pharmacist regarding the new prescription. The offer for counseling must be in a positive, helpful manner. If practical, the offer to counsel must be in person and verbal. Otherwise, it is permissible for the offer to be made in writing or by telephone. Pharmacies are required to provide toll-free access for beneficiary inquiries related to products dispensed. A pharmacist is not required to provide counseling when a beneficiary or representative refuses the offer for counseling.

4.2 DISCUSSION

When the beneficiary (or representative) accepts the offer for counseling, it must be provided by the pharmacist in person (whenever practical) or by telephone and may include written materials. Information must be in a language that can be understood by the beneficiary (or representative) and must include an opportunity for questions.

In addition to discussing interactions with drugs previously dispensed by the pharmacist, the discussion should also include the potential interaction with any other drugs the beneficiary indicates they are taking. The beneficiary (or representative) must be counseled in a confidential manner, consistent with any State or Federal regulations. Federal law requires that the pharmacist must discuss all the items indicated below, and any others deemed significant in the pharmacist's professional judgment. If an interpreter is required, the provider must provide one free of charge.

- The name and description of the medication.
- The dosage form, dosage, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation and use by the beneficiary.
- Common side effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.

SECTION 5 – SIGNATURE LOG, DATA COLLECTION AND DOCUMENTATION

5.1 SIGNATURE LOG

Pharmacy providers must document receipt or delivery of new or refilled medications to the intended Medicaid beneficiary. This documentation serves as verification of the beneficiary receiving the prescription billed. The absence of the appropriate verification indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy. Documentation described below must be retained for review by MDHHS or the MDHHS agent for seven years and is subject to audit. Any method of reproducing past signatures is not acceptable.

5.1.A. SIGNATURE LOG

Pharmacy providers must maintain a log containing the following information:

- Beneficiary's name;
- The manual or electronic signature of the beneficiary or that of their representative; and
- The date of receipt of the prescription.

The log must effectively differentiate between prescriptions received by a beneficiary for which counseling was accepted and provided, and those for which counseling was offered and was declined.

5.1.B. PROOF OF DELIVERY

Pharmacy providers must maintain a log verifying proof of delivery for all prescriptions delivered by common carrier (i.e., FedEx, UPS, USPS, etc.). Pharmacies should be able to link the tracking information to the prescription record through supporting documents if requested. Pharmacies must validate the member's address prior to mailing the prescription. A tracking number alone is not considered a valid proof of member receipt. The tracking number must be accompanied by either:

- the tracking detail from the carrier showing medication was delivered, including date and time of delivery; or
- the manual or electronic signature of the member or that of their representative at the time of delivery.

5.2 BENEFICIARY CONSENT AUTHORIZING ENROLLMENT INTO AUTOMATIC REFILL PROGRAMS

Beneficiary participation in an automatic refill program must be voluntary and opt-in only. Pharmacy providers must obtain beneficiary consent in either written or electronic form prior to enrollment into an automatic refill program for each prescription that will be refilled using the program. The pharmacy shall also obtain an annual renewal consent no later than 12 months since the prescription was previously enrolled in the program. This documentation must be retained for review by MDHHS or the MDHHS agent for seven years and is subject to audit. Any method of reproducing past signatures is not acceptable.

Beneficiary consent documentation for participation in automatic refill programs must include the following information:

- Beneficiary's name;
- The manual or electronic signature of the beneficiary or that of their representative;
- The date of receipt of the signature; and
- Instructions on how to disenroll from the automatic refill program.

Licensed intermediate care facility pharmacy providers are exempt from this requirement. This requirement does not affect retail refill or reminder programs that require the beneficiary to pick up the prescription.

5.3 Beneficiary Information and Data Collection Requirements

To meet specified State and Federal requirements, pharmacies must make a reasonable effort to obtain, record, and maintain on file at least the following information:

- Name, address, telephone number, date of birth (or age), and gender of the beneficiary.
- Pharmacist notes on the beneficiary's drug therapy.
- Beneficiary history when significant, including:
  - Disease state(s);
  - Known allergies and drug reactions; and
  - Comprehensive list of drugs and relevant devices.
- Whether the offer to counsel was made and whether this offer was accepted or rejected by the beneficiary or the beneficiary's representative.

5.4 Documentation Requirements

To assure that pharmacy counseling and other data collection requirements were performed, pharmacies must record the required information in the beneficiary's manual or electronic profile, in the prescription signature log, or any other system of records. Regardless of the format used, the associated documentation must be retained electronically or otherwise for a period of seven years, or longer if specified by law.

5.4.A. Non-controlled Electronically Transmitted Prescriptions

If a prescription is created, signed, transmitted and received electronically, all records related to that prescription must be retained electronically. Records must be retained electronically for a period of seven years, or longer if specified by law. Records must be made available within 72 hours or as requested. The electronically transmitted prescription must include all of the following information:

- The name, address, and telephone number of the prescriber;
- The full name of the patient for whom the prescription is issued;

- An electronic signature or other identifier that specifically identifies and authenticates the prescriber;
- The time and date of the transmission;
- The identity of the pharmacy intended to receive the transmission; and
- Any other information required by the federal act or state law.

The electronic equipment or system utilized in the transmission and communication of prescriptions must provide adequate confidentiality safeguards and be maintained to protect patient confidentiality as required under any applicable federal and state law and to ensure against unauthorized access. The electronic transmission of a prescription must be communicated in a retrievable, recognizable form acceptable to the intended recipient. The electronic form utilized in the transmission of a prescription must not include "dispense as written" or "d.a.w." as the default setting.

Prior to dispensing a prescription that is electronically transmitted, the pharmacist must exercise professional judgment regarding the accuracy, validity, and authenticity of the transmitted prescription. An electronically transmitted prescription that meets the above requirements is the original prescription.

SECTION 6 – GENERAL NONCOVERED SERVICES

This section specifies general coverage restrictions. However, drugs in other classes may not be covered. Pharmacies should review the MPPL for specific coverage. When possible, pharmacies are encouraged to suggest alternative covered therapy to the prescriber if a product is not covered.

The following drug categories are **not covered** as a benefit:

- Agents used for anorexia
- Agents used for weight gain
- Agents used for cosmetic purposes or hair growth
- Agents used for symptomatic relief of cough and colds
- Experimental or investigational drugs
- Agents used to promote fertility
- Agents used to promote smoking cessation not on the MPPL
- Vitamin/Mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation
- Covered outpatient drugs that the Labeler seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the Labeler or their designee
- Covered outpatient drugs where the Labeler limits distribution
- Proposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Over-the-counter drugs not on the MPPL
- Drugs of Labelers not participating in the Rebate Program
- Drugs prescribed for "off label" use if there is no generally accepted medical indication in peer reviewed medical literature (Index Medicus), or listing of such use in standard pharmaceutical references such as Drug Facts and Comparisons, AMA Drug Evaluations, American Hospital Formulary Service Drug Information, or DRUGDEX Information Systems
- Drugs prescribed specifically for medical studies
- Drugs recalled by Labelers
- Drugs past CMS termination dates (Refer to the Directory Appendix for CMS website information.)
- Lifestyle agents
- Standard Infant Formulas
- Drugs covered by the Medicare Part D benefit
- Drugs not FDA approved or licensed for use in the United States
- Agents used for treatment of sexual or erectile dysfunction

SECTION 7 - MICHIGAN PHARMACEUTICAL PRODUCT LIST

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDHHS. The MPPL pharmaceutical product coverages may vary by MDHHS program or be limited by age, clinical parameters, and/or gender. The Point of Sale pharmacy claim adjudication also provides coverage information related to a specific beneficiary or prescription.

The MPPL is posted on the PBM's website. (Refer to the Directory Appendix for website information.) Providers must refer to the MPPL for the additions and deletions of drug products. Specific notification of changes will not be issued.

7.1 NOTIFICATION OF NEW OUTPATIENT DRUGS

MDHHS receives weekly, comprehensive new information about outpatient drugs from First DataBank. Manufacturers are not required to submit notification of new drug products. New drug products are required to be reviewed by the Pharmacy and Therapeutics (P&T) committee.

Most drug products are required to be on the market for six months prior to review. Products with a "priority" FDA rating may be reviewed earlier than the six month requirement.

7.2 APPROVED LABELERS

MDHHS reimburses MPPL products distributed by approved Labelers who have signed rebate agreements with the Centers for Medicare & Medicaid Services (CMS). A list of these approved Labelers is located on the CMS website and identification is by the first five digits of a National Drug Code (NDC). (Refer to the Pharmacy portion of the Directory Appendix for CMS website information.)

Alcohol swabs, condoms, diaphragms, syringes, aerochambers, spacers, and peak flow meters provided by a pharmacy are covered regardless of the manufacturer's rebate agreement.

SECTION 8 – PRIOR AUTHORIZATION

8.1 PRIOR AUTHORIZATION PROCESSOR

The MDHHS PBM processes prior authorizations (PAs). Refer to PBM's Pharmacy Claims Processing Manual for PA procedures. (Refer to the Directory Appendix for contact information.) Authorization to override denial edits must be obtained from the PBM.

Do **not** call the PBM's Call Centers for:

- Supplies billed by Medical Suppliers, including enteral formula and Total Parenteral Nutrition (TPN), since these are only reimbursed to a Medical Supplier provider. Contact the MDHHS Program Review Division for PA. (Refer to the Directory Appendix for contact information.)
- Information about the member's MHP. The provider must contact the MHP to obtain their policies.

8.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for:

- Products as specified in the MPPL. Pharmacies should review the information in the Remarks as certain drugs may have PA only for selected age groups, gender, etc. (e.g., over 17 years).
- Payment above the Maximum Allowable Cost (MAC) rate.
- Prescriptions that exceed MDHHS quantity or dosage limits.
- Medical exception for drugs not listed in the MPPL.
- Medical exception for noncovered drug categories.
- Acute dosage prescriptions beyond MDHHS coverage limits for H2 Antagonists and Proton Pump Inhibitor medications.
- Dispensing a 100-day supply of maintenance medications that are beneficiary-specific and not on the maintenance list.
- Pharmaceutical products included in selected therapeutic classes. These classes include those with products that have minimal clinical differences, the same or similar therapeutic actions, the same or similar outcomes, or have multiple effective generics available.

8.3 RESPONSIBILITY FOR OBTAINING AUTHORIZATION

8.3.A. PHARMACY RESPONSIBILITY

Pharmacies may call the PBM Technical Call Center for exceptions on:

- Quantity;
- Early refills; and
- 72-hour supply of medication for emergency needs only when the prescriber is not available to obtain PA.

Pharmacies may call the PBM Clinical Call Center for exceptions on payment for brand name over the MAC.

The PBM Technical Call Center is available 24 hours per day/seven days a week.

Refer to the Directory Appendix for PBM's Call Center contact information.

8.3.B. Prescriber Responsibility

Prescribers or their designees may call the PBM Clinical Call Center for any PA, but must call for any request that falls outside the categories noted above as applying to pharmacies.

The PBM Clinical Call Center is available after hours by telephone and by pager. The PBM may also be contacted by fax or in writing via U.S. mail.

Refer to the Directory Appendix for the PBM Clinical Call Center contact information, PA contact information and hours of operation.

8.4 Documentation Requirements

For all requests for PA, the following documentation is required:

- Pharmacy name and phone number
- Beneficiary diagnosis and medical reason(s) why another covered drug cannot be used
- Drug name, strength, and form
- Other pharmaceutical products prescribed
- Results of therapeutic alternative medications tried
- MedWatch Form or other clinical information may be required

If prior authorization is being submitted for an item related to a clinical trial, PA requests must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). Refer to the Forms Appendix for a copy of BPHASA-2210.

8.5 Additional Documentation

Depending on the specific drug being prescribed, additional medical documentation may be required. The most common categories requiring additional documentation are:

8.5.A. Brand Override

Provide documentation of the therapeutic trial and failure reasons of the generic.

8.5.B. Anti-Obesity

Prior authorization criteria can be found on the PBM vendor website as 'Clinical and PDL PA Criteria'. (Refer to the Directory Appendix for website information.)

8.5.C. Clinical Trial Attestation Form

For items and services that require prior authorization and were provided in connection with a beneficiary's participation in a qualified clinical trial, a completed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210) is required to be submitted with the pharmacy prior authorization request. Refer to the Forms Appendix for a copy of the form. Refer to the Prior Authorization section of the Directory Appendix for Pharmacy Prior Authorization contact information.

8.6 Prior Authorization Denials

PA denials are conveyed to the requester. PA is denied if:

- The medical necessity is not established.
- Alternative medications are not ruled out.
- Evidence-based research and compendia do not support it.
- It is contraindicated, inappropriate standard of care.
- It does not fall within MDHHS clinical review criteria.
- Documentation required was not provided.

The PBM reviews the information submitted to determine whether the clinical criteria have been met. If the submitted information does not indicate that the criteria have been met, the PA is then sent to the Office of Medical Affairs in MDHHS for final determination on whether the clinical criteria have been met.

SECTION 9 – H2 ANTAGONIST AND PROTON PUMP INHIBITOR POLICY

For high dose use greater than 102 days in a 365-day period, PA is required for H2 Antagonists and Proton Pump Inhibitors (PPIs). MDHHS defines high dose use as:

H2 Receptor Antagonists	Proton Pump Inhibitors
Cimetidine: 800 mg per day or more	Omeprazole: 40 mg per day or more
Famotidine: 40 mg per day or more	Esomeprazole (Nexium): 40 mg per day or more
Nizatidine: 300 mg per day or more	Lansopazole (Prevacid): 30 mg per day or more
Ranitidine: 300 mg per day or more	Rabeprazole (Aciphex): 20 mg per day or more
	Pantoprazole (Protonix): 40 mg per day or more

Nonpreferred H2 Antagonists or PPIs require PA for both high and low dose use. Compliance with the H2 Antagonists and PPI Policy is monitored with POS or post-payment review.

Prescribers may request PA for high dose therapy over the 102 days through the PBM Clinical Call Center. (Refer to the Directory Appendix for contact information.) The following information is required for PA determination:

- Diagnosis
- Drug and dose for which PA is requested
- Date and results of GI testing
- All alternative H2 Antagonists and PPIs tried, including dose and duration
- Other prescribed medications relating to this diagnosis
- Reason patient cannot endure testing
- Health education or other counseling employed for this condition

SECTION 10 – DRUG UTILIZATION REVIEW

10.1 PROSPECTIVE DRUG UTILIZATION REVIEW

MDHHS utilizes Prospective Drug Utilization Review (ProDUR) edits in its Point of Sale (POS) system. ProDUR encompasses drug therapy screening, including problem detection, evaluation, and counseling components of pre-dispensed drugs.

In the POS system, MDHHS limits the number of messages to providers that concern potential drug problems to those that are critical to quality of care and appropriate dispensing. It is the provider's responsibility to provide ProDUR screening and to adhere to beneficiary information and data collection requirements.

10.1.A. PRODUR SCREENING REQUIREMENT

Before prescriptions are filled or delivered, pharmacists must review the consequences of the drug therapy based on the appropriate standards and guidelines.

The review must screen for potential therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications (to the extent diagnosis information is available)
- Drug-drug interactions (including interactions with known over-the-counter drugs)
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse
- Under-utilization or over-utilization

10.1.B. PRODUR ALERT MESSAGES

The PBM's POS system provides online assistance for the dispensing pharmacist. Incoming drug claims are compared to a beneficiary's pharmacy claims history file to detect potential therapeutic problems. ProDUR alert messages are returned to the pharmacist when significant problems are discovered by this review.

10.2 RETROSPECTIVE DRUG UTILIZATION REVIEW

Medicaid utilizes pharmacy data for retrospective drug utilization review (RetroDUR) as required by Federal law and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopoeia Drug Information

- DRUGDEX Information System
- Peer-reviewed medical literature

RetroDUR is intended to be an educational tool to reduce costs resulting from drug-induced illnesses and hospitalizations. The purpose of retrospective drug utilization review is:

- To identify high-risk cases for drug-induced illness.
- To communicate risk factors to prescribers and dispensing pharmacists for evaluation.
- To improve patient healthcare outcomes and quality of care.

RetroDUR alerts providers to a beneficiary's medical condition and total drug usage from all prescribers and pharmacies. The MDHHS PBM reviews utilization data on a monthly basis and makes recommendations to the Michigan DUR Board for interventions and educational seminars.

10.3 Michigan Drug Utilization Review Board

The Michigan Drug Utilization Review (DUR) Board includes both physicians and pharmacists. After post-payment review, the DUR vendor sends appropriate intervention letters to pharmacies and prescribers. Based on the DUR intervention information, prescribers may choose to modify therapy. However, prescribers or pharmacists may also choose to correct beneficiary negative patterns by counseling, or provide background for re-evaluation by the DUR vendor or the DUR Board.

As needed, the PBM or DUR Board follows up on re-occurring patterns that have not been justified. Provider education or academic detailing may be provided to address re-occurring patterns.

10.4 Clinical Consultation

MDHHS provides feedback to providers through its academic detailing program. Administered by PBM, Medicaid targets topics related to drug therapy where direct educational intervention to medical providers may prove beneficial in improving outcomes. The Michigan DUR Board approves the topics for academic detailing. Clinical consultants are Michigan-licensed pharmacists who are recruited and trained through the Michigan Pharmacists Association under the direction of PBM. Whenever possible, clinical consultants are assigned to call on medical providers who practice in the same geographical area as the detailing pharmacist to provide a personal and professional connection between the healthcare providers. Providers are encouraged to give the clinical consultants feedback on both topics presented and the overall program.

SECTION 11 – DISPENSING POLICY

11.1 DAYS SUPPLY

Prescription quantities are limited to the quantity specified by the prescriber. MDHHS covers up to a 34-day supply for acute medications, up to a 102-day supply for maintenance medications, and up to a 12-month supply of contraceptives, including oral, vaginal ring, and contraceptive hormonal patches.

The pharmacy must submit accurate days supply information. Submitting incorrect days supply information can cause false ProDUR messages and claim denials. It could also result in a pharmacy being targeted for a post-payment audit.

11.2 ACUTE AND MAINTENANCE SUPPLIES

Providers must bill and dispense as follows:

- For acute illness: The amount dispensed must be limited to the quantity required for the desired therapy during that episode of illness or up to a 34-day supply.
- For chronic illness:
  - Maintenance drugs must be dispensed in quantities as ordered by the prescriber and to achieve optimum therapy and economy of dispensing, or up to a 102-day supply.
  - If a prescription for a product on the maintenance list is for more than a month's supply and less than a 102-day supply, only one dispensing fee is allowed.
  - A maximum of 13 dispensing fees are paid for the same drug dispensed to the same beneficiary within a 365-day billing period.

A list of maintenance medications is posted on the PBM's website. (Refer to the Directory Appendix for website information.) This list does not exclude medications from other standard therapeutic class codes from being supplied in maintenance quantities. PA is necessary when a maintenance quantity of other medications is required for specific beneficiaries.

11.3 REFILLS

Refills must conform to the current Administrative Rules of the Michigan Board of Pharmacy, Michigan Public Health Code, state and federal statutes, rules, regulations, and policies. Claims will deny at point-of-sale if the utilization requirements have not been met.

For non-controlled substances, a FFS beneficiary cannot obtain a refill of the prescription until at least 75 percent of the drug quantity limit has been consumed in compliance with the prescribed dose, amount, frequency, and time intervals established by MDHHS. (Refer to the Narcotic Analgesics subsection for additional information regarding refill thresholds for narcotic analgesics.)

Early refill overrides may be granted once per drug per 12 months for any of the following circumstances:

- To replace medication that has been lost, stolen or destroyed.
- For the purposes of vacation or travel.

The early refill will not exceed a 34-day supply. MDHHS or its designee may limit the number of instances early refill overrides are approved in cases of suspected fraud or abuse, and may request additional documentation before an override is authorized.

The pharmacy may contact the MDHHS PBM Technical Call Center to request an override for an instance where an early refill is warranted. (Refer to the Directory Appendix for contact information.)

11.4 Prescriptions Not Picked Up

MDHHS does not reimburse for retail prescriptions filled but not dispensed or picked up by the beneficiary or their representative, and does not allow restocking fees. For prescriptions not picked up, pharmacies must claim adjust or reverse the claim for any payments received, including the dispensing fee. The pharmacy should reverse claims in a timely manner. However, MDHHS policy allows claim adjustments or reversals to be submitted up to twelve months after the original date of service. For example, if the Medicaid beneficiary does not pick up a prescription from the pharmacy within 14 calendar days from the date the prescription claim was submitted by the pharmacy, the prescription claim should be reversed on the 15th calendar day and must have been reversed by the 365th day. For audit purposes, a record of processed reversals must be retained by the pharmacy for seven years.

11.5 Tamper Resistant Prescriptions

A pharmacist can only fill a written prescription for a Medicaid FFS beneficiary or POS carveout drugs for MHP enrollees when executed on a tamper resistant prescription pad. (See the following subsections for special considerations.)

Additional information on the tamper resistant prescription pad policy can be found in CMS guidelines which are available online. (Refer to the Directory Appendix for website information.)

11.5.A. Exemptions

- A compliant pad is not required if the prescription is transmitted verbally or electronically by telephone, facsimile, or modem to the pharmacy per federal and state laws.
- MHP enrollee if the MHP is reimbursing the prescriptions.
- Medicaid FFS beneficiaries receiving prescription drugs not separately reimbursable to a pharmacy. This includes drugs provided incident to, or part of, another service or as part of a per diem payment in the following settings:
  - Nursing facilities
  - ICF/IIDs
  - Inpatient/Outpatient Hospitals
  - Clinical Settings (hospice, dental, physician office/clinic, laboratory and x-ray, renal dialysis)

11.5.B. Emergency Prescriptions

In the event a pharmacy receives a non-compliant emergency prescription, the prescribed drug may be dispensed. However, the prescriber must provide to the pharmacy a compliant prescription within 72 hours of the date the emergency prescription was filled.

11.6 Emergency Services Only (ESO) and End Stage Renal Disease (ESRD)

For coverage of medications related to ESRD for an ESO beneficiary, practitioners must identify the appropriate ESRD diagnosis code on prescriptions. Pharmacies should report both the ESRD diagnosis code and required level of service value of '3'.

SECTION 12 – QUANTITY AND BILLING UNITS

MDHHS uses standard metric billing units and the provider may not round fractions. For example, if the product is 2.500 ml, it must be billed as 2.500 ml, not 3 ml. The PBM's processing allows a quantity entry up to 999,999.999.

12.1 QUANTITY LIMITS

Dispensing quantities are limited according to accepted standards of practice, Food and Drug Administration (FDA)-approved Labeler recommendations and the recommendations of the Michigan DUR Board.

12.2 COMMON UNIT BASES

Quantities are based on the amount dispensed for the unit of the product. Thus, quantity field entries must be based on the amount dispensed for the unit specified in the MPPL. The most common unit bases are EACH, ML, or GM. Following are examples.

Drug Name	Drug Strength	Dosage Form	Unit	Billing Quantity Based On
Alphanate		Vial	EA	AntiHemophilic Factor Units
Amoxicillin Trihydrate	125 mg/5 ml	Susp Recon	ML	Reconstituted Milliliters
Cefazolin Sodium	1 gm	Vial	EA	Vials (Powdered-Filled)
Gentamicin Sulfate	40 mg/ml	Vial	ML	Milliliters (Liquid-Filled)
Humulin-N	100 U/ml	Vial	ML	Milliliters (Liquid-Filled)
Indocin	50 mg	Supp Rect	EA	Suppositories
Prolastin		Vial	EA	Milligrams
Proventil Inhaler		Aerosol	GM	Grams in each canister
Ranitidine	300 mg	Tablet	EA	Tablets

SECTION 13 – REIMBURSEMENT, COPAYMENTS, AND COORDINATION OF BENEFITS

Prescriptions dispensed by Tribal 638 facility pharmacies are reimbursed at the Indian Health Services per visit outpatient rate. Refer to the Tribal Health Centers chapter for additional information.

13.1 USUAL AND CUSTOMARY CHARGE

Reimbursement is the lower of the usual and customary (U&C) charge or the MDHHS product cost payment limits and a dispensing fee minus the beneficiary copayment, with the exception of condoms. If a beneficiary has other insurance or Medicare coverage, the related other insurance or Medicare payments are subtracted from the MDHHS payment.

U&C charge is defined as a pharmacy's charge to the general public. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's U&C charge for the same or similar service. The U&C charge must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population.

If a pharmacy discounts prescriptions to an inclusive category of customers (e.g., over 60 years), the pharmacy must reflect this discount in its billings for MDHHS program beneficiaries in the same category.

13.2 OVER-THE-COUNTER DRUGS

The U&C charge for prescription-ordered OTC drugs may be different, but not greater, than the retail pharmacy's shelf price of the same product sold without a prescription.

13.3 SALES TAX

Sales tax must not be added to a pharmacy's U&C charge. MDHHS does not reimburse for sales tax.

13.4 PRODUCT COST PAYMENT LIMITS

Product Cost Payment Limits are based on the NDC the pharmacy identifies as the product that was dispensed. Reimbursement is the lower of the National Average Drug Acquisition Cost (NADAC), the Wholesale Acquisition Cost (WAC), the MAC, or the provider's charge. Misrepresentation of the product's NDC results in denied payment and fraud/abuse sanctions subject to applicable Federal and State laws.

Entities that dispense drugs purchased through the Federal 340B program to beneficiaries must bill the 340B price as the actual acquisition cost.

NADAC rates are posted on the CMS website. (Refer to the Pharmacy Resources portion of the Directory Appendix for website information.)

13.4.A. MAXIMUM ALLOWABLE COST

Maximum Allowable Cost (MAC) reimbursement levels for Michigan Medicaid are established and managed by an MDHHS contractor. MAC reimbursement levels are generally applied to

multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate. New or changed MAC prices are posted on the contractor's website the next business day after they are determined. A monthly online MAC list is also available on the contractor's website. MAC reimbursement reviews will take place on an on-going basis. In addition to the website, specific MAC reimbursement levels are also available by contacting the MAC vendor by US mail, e-mail, fax or telephone. (Refer to the Directory Appendix for the MAC vendor website and contact information.)

All requested MAC price reviews require the following information:

- The brand and generic name, strength, form, and NDC requested for review
- Reason for requested review (availability, price, or other)
- Supporting documentation that the MAC is below cost or the product is not available (wholesaler invoice to support a request)
- Date of service to identify the difference between reimbursement and actual cost
- Prescription number
- Company or pharmacy name, NPI, telephone number, and contact person

13.4.B. MAC Overrides

Specific brand products have a MAC reimbursement level. To receive payment above the MAC reimbursement level, PA through the PBM is required. (Refer to the Directory Appendix for contact information.)

13.5 Professional Dispensing Fees

The professional dispensing fee is defined as the fee charged for filling a prescription and all related services performed by a pharmacy. MDHHS dispensing fees are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

13.6 Beneficiary Copayments

13.6.A. Medicaid Copayments

A copayment for each generic/preferred drug dispensed, and for each brand name/non-preferred drug dispensed, may apply for Medicaid beneficiaries age 21 years and older. A copayment may apply to certain brand name drugs that are preferred. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Copayments cannot be discounted for promotional purposes.

Copayment Exemptions	
Over Age 21 Exclusions	▪ The pharmaceutical product is a family planning or pregnancy-related product. ▪ The beneficiary is in a nursing facility (Benefit Plan ID of NH). (Refer to the Nursing Facility section of this chapter for additional information.) ▪ The beneficiary is enrolled in a hospice program (Benefit Plan ID of Hospice).
Other Exclusions	▪ Medicaid beneficiaries who are under the age of 21 are excluded from the copay requirement. ▪ Native American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x). ▪ All CSHCS, MOMS, and Plan First Family Planning program beneficiaries are excluded, including those over age 21. ▪ Medicare/Medicaid dual eligibles. Claims for the following drugs related to the treatment of Mental Health Conditions and Substance Use Disorders are exempt from copayments: ▪ Central Nervous System Drugs ▪ Psychotherapeutic Drugs ▪ Sedative/Hypnotics ▪ Anti-Alcoholic Preparations ▪ Selective Serotonin Reuptake Inhibitors ▪ Narcotic Withdrawal Therapies ▪ Neuropathic Agents ▪ Opioid antidotes ▪ Drugs used to treat Substance Use Disorder ▪ Drugs used to treat Tobacco Use Disorder

13.6.B. Medicare Part D Copayments

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding co-payment requirements. Beneficiaries may not be denied care or services based on inability to pay a co-payment, except as outlined in that section.

Medicaid will not reimburse:

- Copays, deductibles, or coinsurance for Medicare Part D drugs.
- Commercial insurance drug copays, deductibles, or coinsurance for Medicare/Medicaid beneficiaries who chooses to retain their creditable drug coverage offered by the commercial insurance in place of joining a Medicare Part D plan.
- Copays, deductibles, or coinsurance that exceed the standard Medicare Part D benefit for Medicare/Medicaid beneficiaries.

13.7 Nonallowable Charges to the Beneficiary

A pharmacy must not charge a beneficiary for a prescription if the pharmacy or prescriber fails to request prior authorization (PA). For all products listed in the MPPL indicating PA is required, the pharmacy may contact the PBM for PA or notify the prescriber that a PA is needed.

A pharmacy may charge the beneficiary its U&C charge for a product requiring PA only if the pharmacy has written documentation that the beneficiary was informed of the attempt and failure to obtain PA and of the resultant desire to purchase the drug privately. The pharmacy must not charge any portion of this claim to Medicaid.

The beneficiary must be made aware that PA and reimbursement cannot be obtained later.

13.8 Allowable Charges to the Beneficiary

A pharmacy may only charge a beneficiary the MDHHS established copayment for covered services. A beneficiary may not be charged for any cost of the prescription above the MDHHS reimbursement level. A pharmacy may only charge a beneficiary its usual and customary charge if the service is a noncovered service and the beneficiary has indicated a desire to purchase the service privately. Furthermore, a beneficiary may not be charged for a prescription in lieu of the pharmacy accepting the reimbursement paid by MDHHS, or in lieu of obtaining PA when indicated.

13.9 Advertising

Advertisements must convey only participation in Medicaid. Advertising must not be used to influence the free choice of a pharmacy by a beneficiary. Promotions offering beneficiaries free goods, gift certificates, or shopping sprees in exchange for filled prescriptions are prohibited. No pharmacy may discount the copayment for promotional purposes.

13.10 Coordination of Benefits

Coordination of Benefits (COB) (also referred to as Third Party Liability [TPL]) requires providers to bill other insurances, including Medicare Part B, before billing MDHHS. Pharmacy providers should submit both the primary insurer payment amount and the beneficiary's liability (copayment, coinsurance, and/or deductible) under the primary insurer's plan to MDHHS. Regardless of participation by the pharmacy provider with the other insurance and/or Medicare, MDHHS only reimburses for the coinsurance and deductible amounts up to the Medicaid allowable fee screen. If the other insurance's (including Medicare) reimbursement exceeds the reimbursement level of Medicaid, no additional monies are paid. Providers must submit the charge as the amount allowed by the other insurance, indicating the other insurance payment (including the professional dispensing fee) and the other insurance copayment. In addition, the provider is to use the drug list established by the beneficiary's other insurance carrier. If the other insurance carrier's drug list covers a drug not on the MPPL, the prescriber must obtain PA from MDHHS. (For complete information on MDHHS policy regarding other insurance, refer to the Coordination of Benefits Chapter of this manual.)

If a provider receives payment from another insurance and/or Medicare after MDHHS has made full payment, the payment must be returned to MDHHS through a claim adjustment. Failure to reimburse MDHHS may be construed as fraud under the Medicaid False Claim Act. For billing information on COB, refer to the PBM Pharmacy Claims Processing Manual, the PBM website, or contact the PBM Technical Call Center. (Refer to the Directory Appendix for website and contact information.)

13.10.A. Secondary Payer Coverage of Select Continuous Glucose Monitoring Systems (CGMS), Disposable Insulin Pumps, and Related Supplies

MDHHS allows coordination of benefits for select CGMS and disposable insulin pumps and their respective supplies on the pharmacy claim format where primary insurance only covers these products as a pharmacy benefit and has already been billed. Refer to the Directory Appendix for a list of covered products.

These select products are covered for eligible MDHHS program beneficiaries under the Durable Medical Equipment (DME) program medical benefit when no other insurance applies (or the other insurance covers under the DME benefit).

Pharmacies must submit coordination of benefit claims utilizing one of the following National Council for Prescription Drug Program (NCPDP) Other Coverage Codes:

2	Other coverage exists, payment collected (Coinsurance claim)
4	Other coverage exists, payment not collected (Deductible claim)

Refer to the PBM's Pharmacy Claims Processing Manual for billing procedures. (Refer to the Directory Appendix for website information.)

SECTION 14 – SPECIAL PRODUCT COVERAGE

14.1 AMPHETAMINE

Some drugs used to treat narcolepsy or hyperkinesis may be covered for beneficiaries over 17 years of age. The prescriber or designee must obtain PA before the pharmacy dispenses these products.

14.2 ANTIHEMOPHILIC DRUGS

A Medical Supplier must bill for infusion kits necessary for administration. (Refer to the Medical Supplier Chapter of this manual for additional information.)

Antihemophilic drugs are a Medicare Part B benefit. For beneficiaries who are eligible for both Medicare and Medicaid, the pharmacy must bill Medicare prior to billing Medicaid as explained in the Coordination of Benefits Chapter of this manual.

14.3 ANTINEOPLASTIC DRUGS

Covered chemotherapeutic agents are listed in the MPPL. Most injectable chemotherapy forms are not listed in the MPPL as reimbursement is made to the administering healthcare provider (e.g., physicians, outpatient hospitals). A dosage intended for parenteral infusion (continuous or intermittent), perfusion, or intracavity administration in an office, clinic, or outpatient hospital is not a reimbursable Medicaid benefit to a pharmacy. The pharmacy should bill the ordering provider of service.

Injectable chemotherapy and topical uses for these products may be reimbursed to a pharmacy for home use. Some of these agents may require PA. Refer to the MPPL for verification of PA requirements.

14.4 CLOZAPINE

Clozapine may be billed in weekly cycles. A professional dispensing) fee may be reimbursed each week when billed in accordance with other MDHHS and FDA product licensure guidelines.

14.5 COMPOUNDED DRUGS

Medicaid defines a compounded drug as the combination of two or more ingredients not available from any Labeler in the combination prescribed. Compounded prescriptions must contain at least one product manufactured by an approved Labeler. The following compounded drug policies do not apply to infusion therapy. Additionally, certain Active Pharmaceutical Ingredients (APIs) and excipients utilized in compounded drug claims are covered. MDHHS maintains a list of these covered products on the Michigan Medicaid Pharmacy Benefits Manager (PBM) website. (Refer to the Directory Appendix for PBM website information to obtain the list of covered products.)

14.5.A. EXCLUSIONS

Compounded drugs are not covered if active ingredients include:

- A noncovered legend drug or drug class (e.g., cough/cold, DESI);
- Only OTC drugs;

- Reconstitution of a product only; or
- Pre-mixed infusion solutions (Refer to the Directory Appendix for PBM website information to obtain the list of pre-mixed infusion solutions)

A compounded prescription is not covered if it contains noncovered products and is prescribed solely to circumvent program limitations.

14.5.B. Professional Dispensing Fees

Professional dispensing fees for compounded drugs are available on the MDHHS website. (Refer to the Pharmacy Resources portion of the Directory Appendix for website information.) To receive the compounded fee, a prescription must involve extemporaneous compounding and dispensing prepared only when orders for specific beneficiaries are received.

Medicaid monitors its compounded drug policy on a pre- and post-payment basis.

14.6 Family Planning Supplies

14.6.A. Condoms

Condoms do not require a prescription. A pharmacy may provide condoms at the beneficiary's request. Both males and females are eligible to receive condoms. Condoms are not a covered benefit for participants in the CSHCS program.

- **Payment Limit** – Payment is the lesser of the pharmacy's retail price or the MAC listed in the MPPL. A dispensing fee is not paid for condoms.
- **Dispensing Limits** – The following quantity requirements are monitored by pre- and post-payment reviews. A pharmacy is not reimbursed for more than:
  - 12 condoms at one time to a beneficiary; or
  - 36 condoms in 30 days to a beneficiary.
- **Documentation** – Pharmacies are responsible for maintaining adequate documentation to substantiate which beneficiaries received condoms. Documentation can be collected on a prescription blank or a log entry. Either form of documentation must contain:
  - An assigned control number (e.g., prescription number);
  - Beneficiary name;
  - Beneficiary Medicaid ID number;
  - Brand name of condom dispensed;
  - Quantity dispensed; and
  - Date dispensed.

14.6.B. Diaphragms and Cervical Caps

A dispensing fee is not paid for diaphragms and cervical caps.

14.7 Infusion Therapy

Infusion therapy, except for Total Parental Nutrition (TPN) used in the home setting, is covered for a pharmacy. If a specific drug is not listed in the MPPL, PA must be obtained. A Medical Supplier must bill for infusion-related expendable supplies and durable medical equipment, such as pumps or IV stands and TPN.

MDHHS will reimburse an additional single all-inclusive fee, above the standard dispensing fee, for the diluent and vehicle that is administered with the active ingredient. MDHHS dispensing fees are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Daily billing for infusion therapy is not allowed. Drugs for infusion therapy must not be billed more frequently than seven days.

14.8 Inhalers [Change Made 7/1/2025]

Depending on the beneficiary's condition, several inhalers per month may be necessary. If dispensing limitations allow and the prescriber writes accordingly, the beneficiary may obtain more than one inhaler per prescription. A dispensing fee for inhaler assist devices **(revised 7/1/2025)** is not paid to pharmacies.

14.9 Methadone

Methadone is only covered when used as an analgesic for severe intractable pain such as that produced by some types of terminal illnesses.

14.10 Narcotic Analgesics

A FFS beneficiary cannot obtain a new prescription or refill of an existing narcotic analgesic, whether the drug is prescribed by the same or different healthcare provider or for a different drug in the same class, until 90 percent (95 percent for Benefits Monitoring Program beneficiaries) of the drug quantity limit has been consumed in compliance with the prescribed dose, amount, frequency and time intervals established by MDHHS.

Hospice (Benefit Plan ID of Hospice) beneficiaries are exempt from refill tolerance restriction. Benefits Monitoring Program beneficiaries are also exempt from refill tolerance restriction.

The refill restriction also does not apply if payment from the other insurance is reported on the claim.

The pharmacy may contact the MDHHS PBM Technical Call Center to request an override for an instance where an early refill is warranted. (Refer to the Directory Appendix for contact information.)

14.11 Opioid Withdrawal Agents, Opioid Type

Opioid withdrawal agents may be billed in weekly cycles. Professional dispensing fee limits are extended for this category only.

14.12 Oral Contraceptives

Prescriptions for oral contraceptives may be dispensed for a 12-month supply when the prescriber writes the prescription accordingly.

14.13 Over the Counter Drugs

Covered OTC drugs are listed in the MPPL. A prescription is required. The refill policy is the same as for legend drugs. OTC supply or test kit items that remain in their original packaging should not have a professional dispensing fee requested in the provider's usual and customary charge.

14.13.A. OTC Drugs for End Stage Renal Disease

Certain OTC drugs are covered only for End Stage Renal Disease (ESRD) (that is, prescribed for the treatment of a beneficiary with a kidney transplant or one undergoing maintenance dialysis). Documentation must be kept on file by the pharmacy to substantiate the beneficiary's ESRD condition and must include:

- The date of the transplant (month and year); or
- The name of the facility performing dialysis; or
- An indication that the beneficiary is on Continuous Ambulatory Peritoneal Dialysis (CAPD).

14.13.B. OTC Drugs for Nursing Facilities

The MPPL designates when a covered OTC drug is included in the NF per diem. These products and noncovered OTC drugs are included in the per diem rate paid to a nursing facility. It is the responsibility of the nursing facility to provide these products for its beneficiaries. Reimbursement must be obtained from the nursing facility.

Covered OTC drugs, such as insulin (except if covered by the Medicare Part D benefit) and those not designated as included in the NF rate, are reimbursable to a pharmacy for NF beneficiaries.

14.14 Peak Flow Meters, Spacers, and Aerochambers

Peak flow meters, spacers, and aerochambers listed in the MPPL may be billed by pharmacies. A dispensing fee is not reimbursed to pharmacies that bill for these supplies. Coverage is limited to four (4) peak flow meters per year, and four (4) spacers and/or aerochambers combined total per year.

Spacers and aerochambers cannot be billed by the pharmacy for NF beneficiaries. These items are included in the NF per diem rate.

14.15 Physician-Administered Injectable Drugs [Changes Made 4/1/2025]

Pharmacy claims for the following physician-administered injectable drugs are reimbursable under Michigan Medicaid, Healthy Michigan Plan and Children's Special Health Care Services:

- Mental health and substance abuse injectable drugs, as listed on the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) Physician Injectable Drug Coverage database available on the MDHHS website, administered in an outpatient setting or residential treatment center. (Refer to the Directory Appendix for website information.)
- 17 Alpha Hydroxyprogesterone Caproate (17P), administered in an outpatient setting.

- Injectable drug products covered under the medical benefit and carved-out of Medicaid Health Plan coverage. Refer to the PBM's Pharmacy Claims Processing Manual for billing procedures. (Refer to the Directory Appendix for website information.) **(text added per bulletin MMP 24-62)**

Pharmacy providers may be reimbursed for these injectable drugs for administration using a rate based on the National Drug Code (NDC). The rates for drug product reimbursement are outlined in the Michigan Medicaid State Plan. Professional or institutional claims for physician-administered injectable drugs are also a covered benefit. Pharmacies and prescribing practitioners must ensure that claims are not duplicated. This policy applies to Fee-for-Service claims.

Pharmacy providers may not dispense a physician-administered injectable drug directly to the beneficiary. To ensure the content and integrity of the drug administered to the beneficiary, the drug must be delivered from the pharmacy directly to the physician for administration. The method of delivery of the injectable drug to the physician should be agreed upon by the pharmacy and physician. The refrigeration, stabilization, and other storage and handling requirements of the drug must be met during delivery and at all points of the transaction. The costs associated with the delivery of the injectable drug to the physician are not reimbursable by MDHHS.

The injectable drug must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For multi-dose vials, the first dose must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For the safety of beneficiaries and to minimize waste, procedures should be established to return unused medications to the pharmacy when appropriate. Restocking returned products should be compliant with Michigan Board of Pharmacy guidelines.

14.15.A. Respiratory Syncytial Virus (RSV) Injectables

Enrolled pharmacy providers may bill for covered RSV injectable drugs. (Refer to the Michigan Pharmaceutical Product List subsection for additional information.)

14.16 Vaccines

The cost of the vaccine and administration of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered for adults aged 19 years and older for Fee-For-Service Medicaid, Healthy Michigan Plan, and MOMS program beneficiaries. Additionally, pharmacies approved to participate in the Vaccines for Children (VFC) program may administer ACIP recommended vaccines to Medicaid, Healthy Michigan Plan, and MOMS beneficiaries ages 3 through 18 years. The cost of the VFC vaccine is at no cost to participating pharmacies. VFC enrolled pharmacies can bill administration fees for VFC vaccines as a Medicaid Fee-For-Service pharmacy benefit, including for beneficiaries ages 3 through 18 years of age who are enrolled in a Medicaid Health Plan. (Refer to the Directory Appendix for information on the Vaccines For Children program.)

Pharmacies may submit a claim for COVID-19 and seasonal influenza vaccines and their administration for CSHCS beneficiaries. For beneficiaries 19 years and older who are enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-administered vaccines with the plan.

Pharmacists must be in compliance with State of Michigan rules and regulations and have received the appropriate training for vaccine administration in order to be eligible to administer vaccines. Standing

orders are required from a Michigan-licensed physician who is responsible for the clinical practice of the vaccine operations. This documentation must be readily available onsite in the event of an audit.

Pharmacists who administer vaccines must register with the Michigan Care Improvement Registry (MCIR). This database provides a complete record of immunizations for Michigan residents. Pharmacists must review the beneficiary's immunization history in MCIR prior to administering the vaccine. MCIR must be updated within 72 hours of administering the vaccine.

In order to receive reimbursement for vaccine administration, pharmacies must submit claims through the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

The pharmacy must submit the National Drug Code (NDC) for the product administered and the appropriate values in the Drug Utilization Review (DUR)/Professional Pharmacy Services (PPS) segment and the Professional Service Code respectively. MDHHS allows pharmacies to bill the cost of the vaccine when not purchased through the VFC program. The pharmacy should submit the allowed administrative fee in the incentive fee submitted field.

Dispensing fees are not allowed for the administration of vaccines.

The pharmacy must develop an appropriate mechanism for purposes of properly documenting the identification of the administering pharmacist.

Either a pharmacy or physician can bill for the vaccine administration, but not both. Copayments for vaccine administration services do not apply.

SECTION 15 – NURSING FACILITY

Because of the uniqueness of pharmacy services provided in the nursing facility (NF) setting, separate billing policies were established. Other policies listed in this chapter also apply to NF beneficiaries.

15.1 BENEFIT PLANS

NF beneficiaries typically reside in a nursing home, hospital long term care (LTC) unit, or county-operated medical care facility (MCF). The Benefit Plan ID of NH will be indicated in the eligibility response for beneficiaries who reside in a nursing home.

15.2 DISPENSING FEE

A pharmacy may receive a maximum of 13 dispensing fees for the same drug entity per 365-day billing period.

15.3 COPAYMENT

Medicaid beneficiaries residing in NFs have no pharmacy copayment.

15.4 PHARMACY CONSULTANT SERVICES

Medication reviews and other pharmacy consultant services are the responsibility of the facility and are included in the facility's per diem rate. The pharmacy must make arrangements with the facility for reimbursement of such services.

15.5 PRODUCTS INCLUDED IN THE NURSING FACILITY PER DIEM RATE

MDHHS does not directly reimburse a pharmacy for items included in a facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of the following, arrangements for payment must be between the pharmacy and the facility.

- Medical Supplies - Examples of medical supplies included in the facility's per diem rate are insulin syringes, reagent strips, aerochambers, spacers, peak flow meters, etc.
- Enteral Formulas – Enteral Formulas are included in the facility's per diem rate.
- OTC products not listed in the MPPL as in the NF's per diem rate may be paid directly to a pharmacy by MDHHS. Noncovered OTCs are included in the NF's per diem rate. Examples of OTCs in the per diem include, but are not limited to:

Analgesics	▪ Acetaminophen ▪ Aspirin ▪ Buffered Aspirin ▪ Enteric-coated aspirin ▪ Ibuprofen

Cough/Cold Preparations	▪ Guaifenesin with and without Dextromethorphan ▪ Pseudoephedrine/Chlorphen/Dextromethorphan ▪ Pseudoephedrine/Chlorpheniramine ▪ Pseudoephedrine HCl
Ointments	▪ Vitamins A & D Ointment ▪ White Petroleum ▪ Zinc Oxide
Oral Antiseptics	▪ Mouthwash
Topical Antiseptics	▪ Chlorhexidine Gluconate Wash and Solution ▪ Hydrogen Peroxide ▪ Isopropyl Alcohol ▪ Povidone-Iodine Solution/Wash
Vitamins/Minerals	▪ Calcium Carbonate, Calcium Gluconate, Calcium Lactate ▪ Daily Multiple Vitamin with and without Minerals ▪ Oyster Shell Calcium with and without Vitamin D ▪ Vitamin B1, Vitamin B6 ▪ All other OTC vitamins and minerals
Miscellaneous	▪ Epsom Salts (external use) ▪ Glycerin Suppositories ▪ Milk of Magnesia ▪ Mineral Oil or Emulsions of Mineral Oil ▪ Povidone Douches ▪ Sterile Lubricant ▪ Vinegar Douches ▪ Stool Softeners and stool softeners/laxative combinations

15.6 Drug Returned From Nursing Facility

MDHHS does not reimburse for prescriptions that are not consumed by the beneficiary. The quantity of drug(s) consumed is determined by subtracting the quantity of drug(s) that is returned for the beneficiary from the quantity that was dispensed for the beneficiary. A pharmacy must credit MDHHS for those drugs that are not consumed, except for controlled, adulterated, compromised or unusable. The pharmacy must maintain documentation of the quantity dispensed and consumed by the beneficiary, showing a credit to MDHHS for drugs not consumed.

MDHHS does not allow restocking fees.

SECTION 16 – PUBLIC HEALTH SERVICE AND DISPROPORTIONATE SHARE HOSPITALS

With enactment of Section 602 of the Veterans Healthcare Act of 1992, Public Health Service (PHS) covered entities and selected disproportionate share hospitals (DSH) became eligible for contract drug prices from Labelers (340B Program). A list of participating entities is located on the Bureau of Primary Health Care - Health Resources and Services Administration (HRSA) website. (Refer to the Directory Appendix for website information.)

In addition to these product cost discounts, entities participating in this contract drug program are required by Federal policies to bill drugs covered in the PHS program using the actual acquisition cost for a drug plus a professional dispensing fee. Hospitals can bill up to normal and customary charges for 340B acquired physician-administered drugs or products when provided in the outpatient hospital setting. Actual acquisition cost is defined as the actual invoice cost for a drug product to the pharmacy or company, organization, corporation, or affiliate with which it is associated.

Actual acquisition cost must reflect trade and quantity discounts, rebates, free goods, and price concessions.

On a post-payment basis, MDHHS reviews billings from PHS participating entities to track compliance with this requirement.

Covered entities or their contracted pharmacies, or disproportionate share hospital participating entities that are enrolled as Medicaid pharmacy providers who bill 340B prices, must indicate on the claim that the drug was purchased through the 340B program so their claims can be excluded from the drug rebates. Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.

SECTION 17 – DRUG REBATE PROGRAM

17.1 APPROVED LABELERS AND MPPL

MDHHS covers only those drugs produced by Labelers who have signed rebate agreements with the federal government. Products distributed by companies or a division within a company that did not enroll are not covered.

Approved Labelers are located on the CMS website and are identified by the specific five-digit labeler code (the first five digits of the NDC). (Refer to the Directory Appendix for CMS website information.)

17.2 NATIONAL DRUG CODE ACCURACY

MDHHS invoices pharmaceutical Labelers for rebates quarterly from the pharmacy paid claims history. Pharmacies must bill the actual NDC for a product dispensed. Pharmacies may be contacted periodically to verify product utilization and cost. Contact can include phone or written verification requests. Documentation requirements for verification can include, but are not limited to:

- Copies of the product invoice
- Copies of original prescriptions
- Compounding records

SECTION 18 – BENEFITS MONITORING PROGRAM

The purpose of the Benefits Monitoring Program (BMP) is to monitor and control inappropriate utilization of covered services, including prescribed drugs. (Refer to the Beneficiary Eligibility Chapter for additional information regarding the BMP.)

SECTION 19 – PHARMACY AUDIT AND DOCUMENTATION

19.1 DOCUMENTATION REQUIREMENTS

MDHHS monitors for compliance with Medicaid policy, the Administrative Rules of the Michigan Board of Pharmacy, the Public Health Code, and other applicable federal and state regulations.

The following information serves as a general guide for compliance monitoring during post-payment pharmacy reviews and audits. Additional information regarding audits can be found on the MDHHS post-payment auditor's website. (Refer to the Directory Appendix for website and contact information.) Non-compliance, especially continued non-compliance, may result in payment recovery, sanctions, or referral to the Michigan Attorney General's Office.

340B Drug Pricing Program	Billing ingredient costs may not be higher than actual acquisition costs for drugs procured under the 340B Drug Pricing Program. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.
Automatic Refill Program Consent	Providers must maintain and have accessible the signature of the beneficiary's annual consent of enrollment into an automatic refill program for each prescription enrolled. Missing signatures indicate the beneficiary did not consent to have their prescription enrolled into an automatic refill program. Pharmacies are required to maintain this log for seven years.
Changing Claim Information	Providers may not falsely alter the NDC number, date of service, prescription number, days supply, or any other claim requirement that would allow payment.
Compounds	The compounding of prescription products to gain coverage of noncovered OTC, noncovered legend drugs, or other noncovered categories is prohibited (e.g., the use of injectable Sodium Bicarbonate to compound a Sodium Bicarbonate foot irrigation). Medicaid recovers inappropriate payments for billings found in violation of policy.
CSHCS Only	Pharmaceutical products must relate to the qualifying diagnosis. Payment is recouped for billings for products not related to the qualifying diagnosis.
Days Supply	Accurate days supply information is required. Altering days supply information for purposes of payment will be considered fraud and will be reported to the appropriate unit for investigation. Dosages outside the normal dosage range based on the days supply submitted may prompt a verification request of product usage on reported utilization.
Drug(s) Returned From Nursing Facility	MDHHS does not reimburse for prescriptions that are not consumed by the beneficiary. MDHHS does not allow restocking fees.
Hospice	Pharmacies must not bill MDHHS for prescription services related to the terminal illness except for selected HIV drugs. (Refer to the General Information Section of this chapter for additional information.)
Inaccurate Billing	All claim submission requirements outlined in the PBM Pharmacy Claims Processing Manual must be followed including, but not limited to, accurate Prescription Origin Code, NDC, and NDC unit of measure reporting. The Pharmacy Claims Processing Manual is available on the PBM website. (Refer to the Directory Appendix for website information.)

Medicare Part D	Pharmacies cannot bill Medicaid for drugs covered by Medicare Part D. The Medicaid Program does not coordinate benefits with Medicare Part D.
Other Insurance Payments	Pharmacies must bill other insurances before billing Medicaid. This also applies to Medicare Part B eligible beneficiaries. Failure to bill Medicaid the total due less the amount paid by another insurance or by Medicare Part B may be construed as fraud under the Medicaid False Claim Act.
Prescriber Information	Accurate prescriber information must be provided as required by MCL 400.111b(21). Submitting incorrect prescriber identification numbers can cause false ProDUR messages and claim denials. It could also cause a pharmacy to be targeted for post-payment audit. Pharmacies are audited for inappropriate identification of prescribers.
Prescription Documentation	Original written prescriptions must be executed on tamper resistant prescription pads. If a prescription is created, signed, transmitted, and received electronically, all records related to that prescription must be readily accessible and maintained for seven years. Prescriber medical record documentation may be provided to validate prescriptions. Prescriber affidavits, attestations, and retroactively dated prescriptions will not be accepted for pharmacy documentation. Notation on a pharmacy's database is not considered a written form of the prescription. For originals and all refills, accurate prescription documentation must be readily accessible and maintained for seven years. All of the following information must be entered in the record for each prescription: ▪ prescription number ▪ full name and address of patient for whom the drug is prescribed ▪ prescriber's printed name and address ▪ prescriber's individual NPI ▪ prescriber's DEA (for controlled substance only) ▪ drug name and strength ▪ quantity prescribed ▪ directions for use ▪ number of refills authorized
Prescriptions Filled But Not Picked Up	Retail prescriptions filled but not dispensed or picked up by the beneficiary or their representative. Restocking fees are not allowed. A record of the reversal log must be maintained for seven years for audit purposes.
Professional Dispensing Fees	Pharmacies may not bill in a pattern that would lead to more than 13 professional dispensing fees in a 365-day billing period for the same drug entity. Splitting prescriptions to increase the number of fees paid is considered fraud and will be reported to the appropriate unit for investigation.
Signature Requirement	Providers must maintain and have accessible the signature log indicating beneficiary's pick-up of prescription and acceptance or denial of beneficiary counseling. Missing signatures indicate the prescription was not picked-up or the beneficiary was not offered counseling as required. Pharmacies are required to maintain this log for seven years.
Usual & Customary (U&C) Charge	For specified products, the submitted charge is compared to the cash price to the general public.

19.2 Invoice and Inventory Records

In addition to all other documentation required under state law, federal law, and MDHHS policy, pharmacy providers must maintain invoices, manufacturer and/or wholesaler sales records, distributor delivery records to the provider, inventory transfer records, provider payment records, and all other records necessary to support the size and quantity of the goods paid for by Medicaid during the audit/review period. Failure to do so will result in the recoupment of pharmacy funds related to unsupported Medicaid claims. In the event inventory for any such product cannot be substantiated through reliable documentation for the beginning of the audit/review period, MDHHS may assume that the beginning and ending inventory quantities are the same for that product. For the purposes of this policy, the "audit/review period" shall be a period defined by MDHHS.

19.3 Medication Therapy Management Documentation Requirements

Pharmacists must document each Medication Therapy Management (MTM) service provided. Documentation must include, but is not limited to, the following:

- Beneficiary information
  - Name
  - Address and telephone number
  - Medicaid identification number
  - Gender
  - Date of birth
- Beneficiary's consent for the MTM service, indicated by the beneficiary's signature and date
  - If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing their own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide written consent on the beneficiary's behalf.
- Pharmacist information
  - Name
  - Pharmacist National Provider Identifier (NPI)
  - Pharmacy Name and NPI
- Date of Service
- Place of Service
- Indication of how the beneficiary meets the criteria to receive an MTM service (e.g., meets the chronic condition requirement)
- Indication if this is an initial assessment or follow-up assessment
- Current medical conditions
- Allergies

- Primary physician and contact information

Other information may include the following (items are required if relevant):

- Date of documentation
- Location of beneficiary if service is provided through telemedicine
- Time spent with beneficiary
- Resolved medical conditions
- List of all prescription drugs, along with prescriber information and name of dispensing pharmacy
- List of nonprescription drugs with their indications
- List of drug doses, directions and intended use
- List of all relevant medical devices
- List of all dietary supplements and herbal products
- Alcohol and tobacco use history
- List of environmental factors that impact the beneficiary
- Assessment of drug problems identified, including but not limited to:
  - Determining that the medications are appropriately indicated
  - Determining if the beneficiary needs additional medications
  - Determining if the medications are the most effective products available for the conditions
  - Determining if the medications are dosed appropriately to meet goals of therapy
  - Identifying adverse effects caused by medications
  - Determining if the medications are dosed excessively and causing toxicities
  - Determining if the beneficiary is taking the medications appropriately to meet goals of therapy
  - Evaluating effectiveness and safety of current drug therapy
  - Written plan, including goals and actions needed to resolve issues of current drug therapy
  - Evaluation of success in meeting goals of medication treatment plan
  - Information, instructions and resources delivered to the beneficiary
  - Content of pharmacist's communications to beneficiary's other health care providers
- Description of what was discussed with the beneficiary during the assessment, and whether that information was communicated to the beneficiary's primary care providers

This documentation must be made available to MDHHS upon request. In addition, this documentation and any other relevant documentation may be collected by MDHHS or its designee on an annual basis for the purposes of program evaluation.

SECTION 20 – MEDICAL SUPPLIES

20.1 GENERAL INFORMATION

Covered medical supply items payable (minus a dispensing fee) to a pharmacy are listed in the MPPL. A prescription is required for medical supplies. Covered products include insulin syringes, alcohol swabs, etc.

MDHHS does not separately reimburse a pharmacy for medical supplies dispensed to beneficiaries in nursing facilities, hospital long term care units, or medical care facilities. These items are considered a part of the facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of these items, arrangements for payment must be between the pharmacy and the facility.

Except for those items listed in the MPPL, medical supplies and equipment are covered only when billed by a Medical Supplier or Orthotist/Prosthetist. These items include equipment (e.g., canes), orthotics (e.g., arch supports), prosthetics, oxygen dispensers, wound care dressings (e.g., transparent film, hydrocolloid absorptive dressings, alginate and gel dressing), splints, ace bandages, TPN, enteral and oral nutritional supplements, etc.

When billing as a Medical Supplier or Orthotist/Prosthetist, refer to the Medical Supplier and the Billing & Reimbursement for Professionals Chapters of this manual for additional information.

To enroll as a Medical Supplier, providers must complete an on-line application through the CHAMPS Provider Enrollment subsystem. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional enrollment information, and the Directory Appendix for contact information.)

20.2 SUPPLIES FOR ADMINISTRATION OF PART D DRUGS

MDHHS will reimburse (minus a dispensing fee) a pharmacy for medical supplies and/or equipment (e.g., IV poles, tubing) associated with the administration of Medicare Part D drug(s) to the dual eligibles (except those residing in a nursing facility) for home infusion therapy.

SECTION 21 - MEDICATION THERAPY MANAGEMENT

21.1 OVERVIEW OF MEDICATION THERAPY MANAGEMENT (MTM)

Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. Beneficiaries may elect MTM as an optional service provided by participating pharmacists. (Refer to the Eligible Providers subsection for information on enrolling as an MTM provider.) These services are paid through the Fee-for-Service program for beneficiaries enrolled either in FFS or in a Medicaid Health Plan. There is no cost-sharing responsibility to the beneficiary for the MTM service.

The requirements outlined in the Counseling Requirements section may not be billed as an MTM service.

21.2 COVERED SERVICES

MTM services include the following:

- Obtaining necessary assessments of the beneficiary's health status
- Formulating a medication treatment plan
- Monitoring and evaluating the beneficiary's response to therapy, including safety and effectiveness
- Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Documenting the care delivered and communicating essential information to the beneficiary's other primary care providers
- Referring the beneficiary to their primary care provider or specialist, if necessary
- Providing verbal education and training designed to enhance the beneficiary's understanding and appropriate use of medications
- Providing information, support services, and resources designed to enhance adherence with the beneficiary's therapeutic regimens
- Providing an updated personal medication record and medication action plan for the beneficiary
- Coordinating and integrating MTM services within the broader health care management services being provided to the beneficiary

Any recommended changes to the beneficiary's drug therapy must be approved by the original prescriber(s) of the affected drugs.

Refer to the Medication Therapy Management Documentation Requirements subsection for requirements on documenting MTM services.

21.3 NON-COVERED SERVICES

The following are not eligible to be covered as MTM services:

- Services provided by telephone, email or US Postal Service mail

- Services provided in skilled nursing facilities
- Services provided to more than one beneficiary at a time (i.e., group services)
- Services provided in an inpatient, institutional, or incarceration setting

21.4 Eligible Recipients

Beneficiaries are eligible for MTM services if they are not eligible for Medicare Part D and are taking a medication to treat or prevent one or more chronic conditions as identified in the List of Chronic Conditions for MTM Eligibility. (Refer to the Directory Appendix for website information.)

MTM services must be provided in person with the beneficiary whenever possible. If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing their own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the beneficiary's behalf.

21.5 Eligible Providers

To provide MTM services, a pharmacist must be licensed and have successfully completed either the American Pharmacists Association's "Delivering Medication Therapy Management Services" certificate training program or other MTM program(s) approved by the Accreditation Council of Pharmacy Education.

Pharmacists who meet these requirements must enroll in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) Number as a Rendering/Servicing-Only provider. Under this type of enrollment, pharmacists are required to affiliate themselves with the billing NPI of a pharmacy, Federally Qualified Health Center (FQHC), Tribal Health Center (THC), or Rural Health Clinic (RHC). The pharmacist must enroll as a Non-Physician, with a Pharmacist specialty and the subspecialty of Medication Therapy Management. Individual pharmacists are not eligible for direct Medicaid reimbursement; payment for MTM services will be issued to the affiliated pharmacy, FQHC, THC and/or RHC NPI. Refer to the Provider Enrollment section of the General Information for Providers chapter for more information on this process.

These services may not be delegated by pharmacists to pharmacy technicians or other healthcare professionals.

21.6 Location Requirements

MTM services may be provided in the following settings:

- Ambulatory care outpatient setting
- Clinic
- Pharmacy
- Beneficiary's home if the beneficiary does not reside in a non-covered services setting

These services must be provided in person in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings.

21.7 Telemedicine for MTM Services

In the event that the beneficiary is unable to physically access an in-person care setting, an eligible pharmacist may provide MTM services via telemedicine. Telemedicine is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telemedicine must be obtained through real-time interactions between the beneficiary's physical location (originating site) and the pharmacist provider's physical location (distant site). MTM telemedicine audio/visual services are provided to beneficiaries through hardwire or internet connection. It is the expectation that providers and facilitators involved in telemedicine are trained in the use of equipment and software prior to servicing beneficiaries. The arrangements for telemedicine will be made by the pharmacist. The administration of telemedicine services is subject to the same provision of services that are provided to a beneficiary in person. Providers must ensure the privacy of the beneficiary and secure any information shared via telemedicine. Refer to the Telemedicine chapter for additional information regarding telemedicine service provision.

Refer to the Billing Instructions subsection (of this section) for instructions on indicating the MTM service was provided through telemedicine.

21.8 Billing Instructions

21.8.A Professional Claims

Pharmacy-based MTM claims must be submitted on the professional claim format (HIPAA 837P). The Billing Provider reported on the claim must be the Pharmacy's (Type 2) NPI and be actively enrolled in CHAMPS to be paid. The Rendering Provider reported on the claim must be the Pharmacist's (Type 1) NPI and be actively enrolled in CHAMPS.

For services provided through telemedicine, each procedure code must include the modifier 95. Providers can submit HIPAA 837P electronic claims to CHAMPS through a billing agent, through a batch upload process, or through Direct Data Entry (DDE). Providers can also view claims online and complete claim replacements or voids within CHAMPS.

21.8.B. Institutional Claims

The Billing Provider NPI reported on the claim must be the FQHC, RHC, or THC and be actively enrolled in CHAMPS. The Pharmacist (Type 1) NPI must be reported on the Institutional MTM claim as the Rendering Provider and must be actively enrolled in CHAMPS and associated to the Billing FQHC, RHC, or THC for the date of service. The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the patient's care must be entered as the attending provider. The attending provider field is mandatory to complete.

SECTION 22 – OUTCOMES BASED CONTRACT ARRANGEMENTS

MDHHS utilizes outcomes-based contract arrangements with drug manufacturers for certain high-cost drug products. Under these arrangements, supplemental rebates paid by participating drug manufacturers help offset some of the costs to MDHHS. Drug products for which MDHHS has an outcomes-based contract arrangement are posted on the PBM's website. Reimbursement for these products will be in accordance with established policies and dependent on whether the coverage is billed as a medical or pharmacy benefit. Providers must refer to this list for additions and deletions of drug products. Specific notification of changes will not be issued. Drug manufacturers that are interested in an outcomes-based contract with MDHHS may refer to the PBM's website for MDHHS' CMS-approved Contract Template. (Refer to the Directory Appendix for website information.)

PLAN FIRST FAMILY PLANNING

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SECTION 1 - GENERAL INFORMATION

The Plan First program benefit is limited to family planning services only. The Plan First Family Planning program covers a broad range of family planning services which includes U.S. Food and Drug Administration (FDA)-approved contraceptive products and natural family planning methods for individuals who want to prevent pregnancy and to space births. It also includes pregnancy testing and counseling, sexually transmitted infection (STI) services, and other preconception health services. Decisions about family planning methods, including sterilization procedures, are to be made only with the full and informed consent of the individual, either alone or with support, and free from coercion.

All Plan First enrollees have free choice of family planning providers and may obtain covered family planning services from any qualified Medicaid-enrolled providers. Qualified family planning providers working within their state licensure and scope of practice include, but are not limited to, Title X family planning clinics, Local Health Departments, Federally Qualified Health Centers, Tribal Health Centers, and primary care or obstetrical providers such as physicians, physician assistants, Certified Nurse-Midwives, Nurse Practitioners, and Clinical Nurse Specialists.

SECTION 2 - ELIGIBILITY

To be eligible for this group, an individual must:

- Have income at or below 195% of the Federal Poverty Level (FPL) under the Modified Adjusted Gross Income (MAGI) methodology;
- Not be pregnant at the time of application;
- Be a resident of the state of Michigan; and
- Meet Medicaid citizenship and immigration requirements.

There are no gender or age requirements to be eligible for Plan First.

SECTION 3 - SERVICES

3.1 COVERED SERVICES

The Plan First program includes the following covered services:

- Office Visits:
  - Family planning services, including preconception counseling, contraceptive counseling, and physical exams.
  - Preventive services, including annual wellness exams, preventive screening, counseling, and vaccines, including Human Papilloma Virus (HPV) and Hepatitis B.
  - Diagnostic procedures, counseling, and follow-up visits to diagnose and/or treat an STI or STI-related condition identified or diagnosed at a family planning visit.
  - Counseling for the prevention, screening, and diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and hepatitis.
  - Treatment of pre-cancerous conditions which commonly originate from an STI.
  - Basic diagnostic infertility services, including infertility counseling.
  - Treatment of major complications related to family planning services and family planning-related procedures.

  (Refer to the Practitioner Chapter for additional coverage information.)
- Laboratory Services:
  - Pregnancy testing.
  - Screening for cervical cancer.
  - Screening and counseling for STIs, HIV/AIDS, and hepatitis.

  (Refer to the Laboratory Chapter for additional coverage information.)
- Pharmaceutical Services:
  - All FDA-approved methods of contraception supplies and devices to prevent or delay pregnancy.
  - Over-the-counter contraceptives and supplies, such as condoms, spermicides, and sponges.
  - Pharmaceuticals to treat an STI or STI-related condition routinely identified or diagnosed at a family planning visit (other than HIV/AIDS or hepatitis).
  - HIV post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP)

  (Refer to the Pharmacy Chapter for additional coverage information.)
- Sterilization Procedure Services:
  - Voluntary sterilization surgical procedures and follow-up care provided in accordance with Medicaid program coverage.

Refer to the Sterilization subsections of the Practitioner and Hospital Chapters of this Manual for other coverage requirements related to sterilizations.

3.2 Non-covered Services

The Plan First program does not cover the following:

- Abortions
- Treatment of infertility, such as drugs or artificial insemination
- Reversal of voluntary sterilization
- Hysterectomies for sterilization
- Treatment, including pharmaceuticals, for conditions not related to family planning, such as cancer, HIV/AIDS, or hepatitis
- Inpatient hospital services

SECTION 4 – ADDITIONAL INFORMATION

Family planning services are not subject to beneficiary cost-sharing, including co-pays.

Providers must report an appropriate family planning-related diagnosis code on the associated claim line for family planning services.

Family planning services covered under the Plan First program are limited to those drug classes and Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) and ICD-10-CM codes located on the MDHHS website. (Refer to the Directory Appendix for website information.)

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SECTION 1 – GENERAL INFORMATION

This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons (MD, DO), Doctors of Podiatric Medicine (DPM), Physician Assistants (PAs), Medical Clinics, Advanced Practice Registered Nurses (APRNs) [including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), and Certified Nurse-Midwives (CNMs)], Certified Registered Nurse Anesthetists (CRNAs), Anesthesiologist Assistants (AAs), and Genetic Counselors.

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. This includes, but is not limited to, medically necessary health care services that are evidence-based and provided within generally accepted standards of medical practice to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.1 ADMINISTRATIVE SERVICES

Services of physicians, medical staff or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for hospital or nursing facility quality improvement purposes or other reasons which do not directly assist with the specific care of a specific beneficiary are considered to be administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

1.2 COMPONENT SERVICES

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician (e.g., interpretation of results and preparation of a report of findings).

Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment, supplies, and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the components are covered for the physician are identified in the Medicaid Code and Rate Reference tool or on the MDHHS Practitioner and Medical Clinic Fee Schedule. (Refer to the Directory Appendix for website information.)

Global services are covered for the physician in non-facility settings or the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

1.3 Copayments

A copayment may be required for physician office (evaluation and management) visits for beneficiaries age 21 years and older.

The office visit copayment applies to services provided in the physician's office, urgent care center, or other appropriate setting. It does not apply to professional services provided in the outpatient hospital or inpatient hospital settings. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Podiatrists should refer to the Podiatrist Section of this chapter for information regarding beneficiary copayments for podiatry services.

Ophthalmologists providing routine vision services should also refer to the Vision Chapter for information regarding beneficiary copayments for vision services.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.4 Facility and Nonfacility Reimbursement

Medicaid reduces payment for specified procedures provided in a facility setting. This policy is consistent with the Centers for Medicare & Medicaid Services (CMS) facility and nonfacility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced because the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a nonfacility setting, the payment rate is based on the nonfacility relative value units (RVUs). When the service is provided in a facility setting, the payment rate is based on the facility RVUs. The payment difference takes into account the higher expenses for the provider in the nonfacility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities
- Psychiatric facilities
- Skilled nursing facilities
- Ambulatory surgery centers
- Rehabilitation facilities

1.5 Hospital-Based Provider

Medicaid covers services by hospital-based providers (HBPs). A hospital-based provider is employed by the hospital. Each HBP is assigned their own NPI number.

For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as physician assistants (PAs), certified registered nurse anesthetists (CRNAs), and advanced practice registered nurses (APRNs), can also be considered HBPs under certain circumstances.

Medicaid follows Medicare guidelines for the coverage of HBP services provided by physicians. Generally, professional services provided by nonphysician providers that are employed by a hospital are included in the hospital cost report and are reimbursed to the hospital.

(The HBP should refer to their provider-specific section of this chapter for policies, procedures, and coverage information.)

1.6 Medicare Related Services

MDHHS reimburses practitioners for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

1.7 Physician Delegation and Supervision

Physician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision in accordance with State law, professional scope of practice, and program and organizational policy. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., advanced practice registered nurse or physician assistant) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises. Delegated and supervised services rendered by non-physician practitioners (e.g., advanced practice registered nurses, physician assistants) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.

In the physician's absence, licensed persons who are under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries may provide medical services. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

Medicaid covers services delegated to unlicensed/certified persons only when the delegating physician or licensed non-physician practitioner is physically present and providing direct supervision. For information related to services provided by an advanced practice registered nurse or physician assistant under the

terms of a valid collaborative, practice or alliance agreement, refer to the provider-specific section of this chapter.

1.8 Physician Responsibility

Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if they order excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a physician to be covered by Medicaid. Some services provided by other providers, such as medical supplies, lab services, and prescriptions, may require the physician to provide written documentation to support the need for the service. For specifics regarding whether a service is a covered benefit, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.)

1.9 Prior Authorization [Change Made 7/1/2025]

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
- Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use of non-protected drug classes, etc.). **(revised per bulletin MMP 25-12)**
- Referrals for elective services by out-of-state nonenrolled providers.

1.9.A. To Obtain Prior Authorization

Requests for PA for practitioner services such as surgeries, procedures, office-administered pharmaceuticals, biologicals, and out-of-state-care must be submitted utilizing the Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B). (Refer to the Forms Appendix for a copy of the form or download the form from the MDHHS website.) The form must be completed in its entirety. Supportive medical documentation must accompany the form.

Providers receive a written response from MDHHS. If the authorization is granted, the provider receives a PA number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If

Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

1.9.B. Special Authorizations

Special authorization requirements must be met for selected surgeries performed in the inpatient setting, all elective inpatient admissions, all readmissions within 15 days, and all transfers to an inpatient hospital/unit. Physicians should refer to the Hospital Inpatient Physician Services and the Surgery Sections of this chapter for specific information.

Some beneficiaries may need authorization of services because they are enrolled in special programs, such as the Benefits Monitoring Program. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.10 Services in a Teaching Setting

Administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS for Medicare. Services covered by Medicaid under these guidelines must be identified with the appropriate modifier.

Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by Medicaid or must be included as allowable medical education costs in the hospital's cost report.

Guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved and the teaching physician seeks payment (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply; therefore, the full text of the guidelines must be consulted to ensure compliance.

CMS provides an exception to the physician presence requirement for some low- and mid-level Evaluation and Management (E/M) services furnished within a teaching setting when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the primary care exception for primary care services provided by residents. Under the CMS primary care exception, time cannot be used to select a visit level, only medical decision making (MDM). The appropriate modifier must be reported using the primary care exception when residents provide E/M services. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.

Services of residents or physicians/medical staff functioning in an administrative, teaching or learning capacity in the hospital or long term care facility that are covered as individual physician services are

subject to post payment review and recovery of funds unless the provider can present proof that the services were not included in the allowable facility costs.

1.11 Services to Newborns

Physician services provided to newborns are covered under the newborn's Medicaid ID number. The mother's Medicaid ID number cannot be used.

If the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay, these services can be covered under the mother's Medicaid ID number if they are billed on the same claim as the services to the mother.

1.12 Uniform Reporting of Services

MDHHS follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.

SECTION 2 – ANESTHESIA SERVICES

Medicaid covers anesthesia and analgesia services when provided by qualified health care professional acting within their professional scope of practice and within the requirements of State law and facility policy.

2.1 ANESTHESIA PROVIDERS

Practitioners qualified to administer anesthesia may include the following:

- Physician;
- Dentist;
- Podiatrist;
- Certified registered nurse anesthetist (CRNA); or
- Certified anesthesiology assistant (AA) providing anesthesia services under the supervision of an anesthesiologist.

The anesthesia provider is responsible for the anesthesia care package, which consists of pre-operative evaluation, standard preparation and monitoring services, administration of anesthesia, blood products and fluids, post-anesthesia recovery care, and supportive services. There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the reimbursement for the surgical procedure itself.

2.2 LEVELS OF SEDATION/ANALGESIA

The continuum of anesthesia services, from least intense to most intense in complexity, is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia, and general anesthesia. MDHHS recognizes the following definition of general anesthesia and levels of sedation/analgesia:

Minimal Sedation (Anxiolysis)	Drug-induced state during which individuals respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected.
Moderate Sedation/Analgesia (Conscious Sedation)	Drug-induced depression of consciousness during which individuals respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. During moderate sedation, the responsible physician typically assumes the dual role of performing the procedure and supervising the sedation.
Deep Sedation/ Analgesia	Drug-induced depression of consciousness during which individuals cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Individuals may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia	Drug-induced loss of consciousness during which individuals are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Individuals often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

2.3 Coverage of Anesthesia Services

Medicaid covers anesthesia services associated with Medicaid covered surgeries and other procedures. Covered anesthesia services include medically directed, non-medically directed, and monitored anesthesia care. Moderate sedation is also a covered service. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter or the Medicaid Code and Rate Reference tool for more information regarding coverage parameters. (Refer to the Directory Appendix for website information.)

2.3.A. Medically Directed Anesthesia

Medicaid covers anesthesia services provided by physicians (anesthesiologists), CRNAs, and AAs for medically directed anesthesia services consistent with anesthesia team practice. (Refer to the Certified Registered Nurse Anesthetist section and/or the Anesthesiologist Assistant section of this policy for additional information). Medicaid recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary MAC.

Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologist assistants*, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases, and the physician performs the following activities:

- Performs the pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding services in the anesthesia plan including, if applicable, induction and emergence;
- Ensures that a qualified individual performs any services in the anesthesia plan that the physician does not personally perform;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

Physicians must document in the beneficiary's medical record that they performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and present during the most demanding services, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record. The pre-anesthetic exam

and post-anesthesia evaluation is included in payment for the medically directed services and generally not separately reimbursed.

*Anesthesiologist assistants must be medically directed by a Medicaid-enrolled anesthesiologist and must comply with the requirements for the delegation and supervision of services in the Michigan Public Health Code.

Physicians cannot medically direct more than four concurrent anesthesia cases at one time. Concurrency refers to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on only the cases involving a Medicaid beneficiary but the entirety of the number of medically directed cases.

A physician who is providing medical direction of anesthesia care generally cannot provide additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met. However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and, therefore, are not paid under the fee schedule.

In select instances, medically directed anesthesia services are covered when provided by a physician who is monitoring more than four concurrent anesthesia services, or who is performing other services while directing the concurrent services, as medically supervised services. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment may be made to cover the physician's involvement in the pre-surgical anesthesia services.

If physicians are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

2.3.B. Non-Medically Directed Anesthesia Services by the CRNA

Anesthesia services provided by the independent CRNA or CRNA under the supervision of the surgeon, or other physician who is immediately available, are covered as non-medically directed anesthesia services. MDHHS reimburses CRNAs for these services if all the following conditions are met:

- CRNA services are provided in accordance with supervision requirements established by state law.
- The facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner.
- The facility is responsible for all anesthesia administered in the facility.
- The CRNA provided a pre-anesthetic exam and evaluation within 48 hours prior to the surgery.
- An intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician, where applicable.
- The CRNA completes a post-anesthesia follow-up report within 48 hours after surgery for inpatients.
- For outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for physicians for any portion of non-medically directed anesthesia services. The physician's supervisory service is included in the facility charge. The pre-anesthetic exam and post-anesthesia evaluation are included in payment for the non-medically directed CRNA care and are generally not separately reimbursed. Reimbursement for the non-medically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

2.3.C. Monitored Anesthesia Care (MAC)

MAC is a specific anesthesia service performed by a physician, non-medically directed CRNA, or other qualified anesthesia practitioner under the medical direction of a physician for a diagnostic or therapeutic procedure or in anticipation of the need for administration of general anesthesia. Services may include varying levels of sedation, awareness, analgesia and anxiolysis as necessary. MAC does not describe the continuum of depth of sedation.

MAC is covered on the same basis as other anesthesia services if it is reasonable and medically necessary. MAC includes all aspects of anesthesia care, including a pre-procedure assessment and optimization, intraprocedural care including the administration of sedatives, analgesics, hypnotics, anesthetic agents, or other medications as necessary, and post-procedural management. Indications for MAC include, but are not limited to, the nature of the procedure, the beneficiary's clinical condition and/or the need for deeper levels of analgesia/sedation than can be provided by moderate sedation (including potential conversion to a general or regional anesthetic).

2.3.D. Moderate Sedation Services

Moderate sedation services (e.g., CPTs 99151-99157) are reimbursed utilizing the annual Resource Based Relative Value Scale (RBRVS) multiplied by the State conversion factor. Rates are published on the Physician/Practitioner/Medical Clinics fee schedules. Codes representing moderate sedation are not to be reported for the administration of minimal

sedation, deep sedation, general anesthesia or monitored anesthesia care (CPT codes 00100-01999).

2.4 Coverage of Anesthesia Services for Specific Procedures

2.4.A. Medical Services

Separate coverage is available for certain medical or surgical services furnished by a provider while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the beneficiary or as single services (e.g., the day of or the day before the anesthesia service). These services include insertion of a Swan Ganz catheter, insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services such as the pre-anesthetic examination of the beneficiary, pre- or post-operative visits, or usual monitoring functions that are ordinarily included in the anesthesia service.

2.4.B. Anesthesia Performed in Conjunction with Services that Require Prior Authorization

If a surgical procedure requires prior authorization (PA), the surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized. (Refer to the General Information for Providers chapter of this manual for information regarding PA of services.)

2.4.C. Post-Operative Pain Management

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code (e.g., CPT 01996) when the anesthesia practitioner performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

2.4.D. Electro-Convulsive Therapy

Anesthesia services related to electro-convulsive therapy (ECT) are covered by the beneficiary's Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the PIHP/CMHSP or the MHP. Payment is made by the PIHP/CMHSP or MHP that authorized the service.

2.4.E. Labor and Delivery

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

Time for obstetric epidural anesthesia during labor and vaginal and cesarean section deliveries begins with insertion and ends with removal of the epidural catheter. Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session.

2.4.F. Hysterectomy and Sterilization

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid consent requirements before the service can be rendered. It is the responsibility of the operating surgeon to obtain this consent. (Refer to the Surgery – Special Considerations section of this chapter for additional information for hysterectomies and sterilizations.)

2.5 Special Considerations

2.5.A. Multiple Anesthesia Services

Report the anesthesia code with the highest Base Unit Value when multiple surgical procedures are performed during a single anesthesia administration. The time reported is the combined total for all procedures performed on the same beneficiary on the same date of service by the same or different physician or other qualified health care professional.

2.5.B. Discontinued Anesthesia Services

In the instance a procedure is cancelled or discontinued after general or regional anesthesia induction has occurred, report the anesthesia base code corresponding to the surgical procedure plus the time expended providing the anesthesia service in minutes.

When a procedure is cancelled after the pre-operative evaluation, reimbursement may be made to the anesthesiologist or the independent CRNA when the appropriate Evaluation and Management (E&M) code is reported.

2.5.C. Teaching Services

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an attending provider relationship in a teaching hospital and/or in accordance with the coverage and reimbursement guidelines established by the Medicare policies for teaching practitioners. (Refer to the Services in a Teaching Setting section of this chapter for additional information.)

SECTION 3 – GENERAL PRACTICE

3.1 ALLERGY TESTING AND IMMUNOTHERAPY

Medicaid covers allergy testing and immunotherapy services. Testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. A visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the test results in relation to the history and physical examination of the beneficiary.

Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who actually prepares and provides the antigens/venoms are covered on a per dose basis. Services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

MDHHS assumes antigens are prepared for administration over a period of time in increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. Medicaid covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are not covered.

3.2 AMBULANCE SERVICES

Coverage for ambulance services is restricted to medically necessary and appropriate services when medical/surgical or psychiatric emergencies exist or no other effective or less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Emergency ambulance services do not require a physician's order.

The physician must order all non-emergency, medically necessary ambulance transportation. Refer to the Ambulance Chapter for order requirements and additional information related to ambulance services.

3.3 AUDIOLOGICAL AND HEARING SERVICES

Medicaid covers hearing evaluations and other audiological function testing by a physician, physician assistant, or advanced practice registered nurse. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings.

A hearing aid is covered if all of the following criteria are met:

- The practitioner performs a medical evaluation within six months prior to the beneficiary obtaining a hearing aid. For beneficiaries under age 18, an otolaryngologist or other appropriate specialty physician must complete the evaluation.
- The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid.

- The practitioner prescribes a hearing aid.
- The beneficiary presents the prescription and a written statement of the medical clearance to an enrolled hearing center or audiologist for audiological testing and a hearing aid exam.
- The beneficiary is referred to an enrolled hearing aid dealer, hearing center, or audiologist for the selection and provision of the aid.

3.3.A. Newborn Hearing Screening Examination

MDHHS requires that all Medicaid-covered newborns be screened using the automated auditory brainstem response (ABR) method and/or the automated evoked otoacoustic emissions (EOAE) method.

Results must be reported to the child's primary care provider in a timely manner.

If the birthing hospital has the appropriate equipment, the screening must be done at the hospital. When this occurs, the screening is covered as a part of the inpatient stay.

If the hospital is not equipped for ABR or EOAE, the child's physician, CNM, or NP must refer the newborn to a Medicaid enrolled hearing center where screening must be completed prior to one month of age.

Refer to the Hearing Services subsection of the Hospital Chapter for additional information.

3.3.B. Local Health Department Screenings

The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department (LHD) for objective hearing screening. The results of the screening must be reported to the child's primary care provider. If the LHD is unable to report the results to the child's primary care provider, the LHD must clearly document why this was not accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

MDHHS monitors the number of MHP referrals reported by LHDs, and may initiate charge-backs to the plans.

Refer to the Additional Information on Objective Hearing & Vision Screening subsection of the Local Health Department Chapter for additional information.

3.4 Care of Abused Children

Medicaid covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, they must immediately contact the appropriate Protective Services Unit of the local MDHHS office to report their suspicions.

Medicaid covers the inpatient stay of an abused or neglected child when, upon admission, the attending provider determines that the child requires further assessment and treatment which is best provided on an inpatient basis.

Healthcare providers cannot admit a child to the hospital for the sole purpose of custodial or protective care.

3.5 Childbirth/Parenting Education

Medicaid covers childbirth/parenting education for pregnant women when referred in writing by the prenatal care provider and provided by qualified educators in a Medicare certified outpatient hospital or by a certified Maternal Infant Health Program (MIHP) program provider.

This service is not covered if rendered by the prenatal care provider in the office setting.

3.6 Clinical Trials

The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are any item or service provided to the beneficiary under the qualifying clinical trial.

3.6.A. Covered Items and Services

Routine patient costs include any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. Routine patient costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Examples of routine costs include otherwise covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring, or treatment of complications arising from clinical trial participation.

3.6.B. Non-covered Items and Services

Items and services considered experimental or investigational are not a covered benefit. This includes the experimental or investigational drug, item, or service that is the subject of the qualifying clinical trial. Other non-covered items and services include:

- Items and services not otherwise covered by the Medicaid program;
- Items and services provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that are not used in the direct clinical management of the beneficiary; and
- Items and services provided by the trial sponsor without charge.

3.6.C. Qualifying Clinical Trial

A qualifying clinical trial is defined to include a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. A qualifying clinical trial must also be one or more of the following:

- A study or investigation that is approved, conducted, or supported (including funding through in-kind contributions) by one or more of the following:
  - the National Institutes of Health (NIH);
  - the Centers for Disease Control and Prevention (CDC);
  - the Agency for Healthcare Research and Quality (AHRQ);
  - the Centers for Medicare & Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above, or the Department of Defense or the Department of Veterans Affairs; and
  - a qualified non-governmental research entity identified in the guidelines issued by NIH for center support grants.
- A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review in compliance with Section 210 of the Consolidated Appropriations Act:
  - the Department of Energy
  - the Department of Veterans Affairs
  - the Department of Defense
- A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or
- A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.

3.6.D. Determination for Coverage

Determination for coverage of costs associated with a beneficiary participating in a qualifying clinical trial shall be made with the following considerations:

- Expedited and completed within 72 hours;
- Made without limitation on the geographic location of where the clinical trial is conducted or based on the network affiliation of the principal investigator or provider treating the beneficiary in connection with the clinical trial;
- Based on attestation of the principal investigator or provider regarding the appropriateness of the qualifying clinical trial via the Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210); and

- Shall not require the submission of protocols of the qualifying clinical trial or any other documentation that may be proprietary.

3.6.E. Attestation to the Appropriateness of the Qualified Clinical Trial

A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210) must be submitted with all claims and PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial. The form represents the attestation by the principal investigator and health care provider to the appropriateness of the clinical trial.

The BPHASA-2210 must be signed by both the principal investigator of the clinical trial and a qualified health care provider. Qualified health care providers include licensed providers who are part of the beneficiary's health care team such as, but not limited to; the beneficiary's primary care, specialty, treating, referring, or ordering provider, pharmacist, or the principal investigator of the clinical trial. The completed form must be submitted with all claims and PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial. (Refer to the Forms Appendix for form BPHASA-2210.)

3.6.F. Prior Authorization

Not all items and services associated with a clinical trial require prior authorization (PA). All PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial must include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). Refer to the General Information for Providers Chapter for additional PA requirements.

3.6.G. Claims for Services

All claims for routine patient costs associated with participation in a clinical trial must include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210), the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial, such as Z00.6 (encounter for examination for normal comparison and control in clinical research program). Claims may also include any future ICD-10 diagnosis code(s) that falls within the structure and conventions of the classification and general guidelines applicable to clinical trial services as established by CMS and National Center for Health Statistics (NCHS) services.

Refer to the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters for additional claim requirements for services associated with participation in a clinical trial.

3.7 Communicable Disease Treatment

Medicaid covers the diagnosis and treatment of communicable diseases, including tuberculosis (TB), hepatitis, meningitis, and enteric disease. Cases of communicable disease must be reported to the LHD.

Providers may obtain additional information regarding communicable disease prevention and control from the LHD.

3.8 Diabetes Patient Education

Medicaid covers diabetes self-management education for beneficiaries diagnosed with diabetes when ordered by an enrolled physician or qualified non-physician medical practitioner responsible for the beneficiary's diabetic care. Services must be provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or LHD that meets Michigan Medicaid DSME program requirements.

The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis and any special needs supported by medical necessity in the medical record.

Refer to the Hospital Chapter of this manual for information about DSME program requirements.

3.9 Diagnostic Tests

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary. The ordering or referring of specific diagnostic tests may be restricted to physicians (MD or DO) by program policy.

3.10 Family Planning

Medicaid covers family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis). A visit for family planning typically includes a complete physical examination, including a pelvic examination.

Separately identifiable services provided in addition to the examination are covered separately. Counseling for family planning services, including sterilization, is covered as a part of the family planning visit.

Medicaid covers contraceptives including:

- Oral contraceptives (must be prescribed by a physician and dispensed by an enrolled pharmacy or Family Planning Clinic)
- Diaphragms
- Intrauterine devices
- Condoms (available from a pharmacy without a prescription, or from a family planning clinic)
- Foams, gels, sponges (must be prescribed by a physician and dispensed by a pharmacy or family planning clinic)

3.11 Foot Care

3.11.A. Routine Foot Care

Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient

severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record, and the beneficiary must be receiving regular care from a physician for the systemic disease.

3.11.B. Mycotic Nails, Debridement

Medicaid covers debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection. Documentation in the beneficiary's medical record must support clinical evidence of the mycosis, identification of the toenail(s) affected, and evidence that the mycosis is likely to result in significant medical complications if appropriate antifungal treatment is not rendered.

The debridement of mycotic nails is covered for beneficiaries in the nursing facility only on the written order of the attending physician (MD or DO). The order must be patient-specific and not for routine care only.

3.12 Fracture Care

Medicaid covers medically necessary fracture care. Coverage includes the initial traction, cast application and removal, and routine follow-up care. Additional reductions are independent procedures not included in the original treatment and are covered separately.

Fracture care includes the insertion and removal of necessary wires, pins, etc. If the wire, pins, etc., are the types that are not normally removed but the removal is medically necessary, Medicaid also covers such removal. Documentation of the need must be included on the claim.

Coverage also includes subsequent recasting required during the course of fracture treatment (i.e., following initial cast application). Medicaid covers cast removal as a separate service only when performed by a physician who was not involved in the fracture care and who is not reapplying another cast.

3.13 Gender Affirmation Services

The Medicaid program covers medically necessary gender affirmation/ confirming medical, surgical, and pharmacologic treatments and procedures for beneficiaries clinically diagnosed with gender dysphoria. Treatment and procedures for the health management of individuals with gender dysphoria are not considered to be elective or cosmetic when determined to be medically necessary. Medical and mental health services, determination of medical necessity, as well as the relevant qualifications and clinical experience requirements of treating providers, must adhere to the most current clinical practice guidelines, including those established by the World Professional Association for Transgender Health (WPATH) and the Endocrine Society, as applicable.

3.14 Genetic Counseling

Medicaid covers medically necessary genetic counseling services as defined in section 333.17001 (Act 368 of 1978) when provided by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs). Genetic counseling may also be provided by a licensed Medicaid-enrolled Genetic Counselor when ordered by a physician, PA, or APRN.

Counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Counseling is considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background.

Genetic tests recommended as a result of genetic counseling may be covered when provided in accordance with Medicaid's Genetic and Molecular Testing policy. Providers should refer to the Genetic and Molecular Testing subsection of the Laboratory Chapter for information on genetic testing.

3.15 Immunizations (Vaccines and Toxoids)

Immunizations are covered when given according to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations. This includes ACIP recommendations based on risk due to health condition, occupation, and travel. MDHHS encourages providers to immunize all Medicaid beneficiaries according to the recommended immunization schedules.

- For Medicaid children 18 years and younger, the Vaccine for Children (VFC) Program provides covered immunizations at no cost to the provider.
- Medicaid covers immunizations for beneficiaries 19 years of age or older.
- Any Local Health Department (LHD) in the state can be contacted for specifics about the VFC program, what immunizations are available, and instructions on enrolling and obtaining immunizations.

Medicaid does not pay for immunization costs for any product that is available free of charge for Medicaid beneficiaries. An administration fee is covered separately for immunizations given to Medicaid beneficiaries whether the immunization is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

For immunizations available free under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is $5.00, then the charge for immunization administration to the Medicaid patient cannot exceed $5.00.

For Medicaid beneficiaries enrolled in an MHP, the health plan must ensure that the beneficiary has access to receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes immunizations), the provider should immunize the beneficiaries assigned to them by the plan. MHP providers enrolled in the VFC program are encouraged to immunize and are discouraged from referring beneficiaries to a LHD for these services.

If a beneficiary is in a nursing facility, the facility is responsible for appropriately immunizing the beneficiary. Coverage of the immunizations is included in the per diem payment made to the facility.

3.16 Injectable Drugs and Biological Products

3.16.A. Coverage of the Injectable

Medicaid covers injectable drugs and biological products administered by a physician in the office, clinic setting, and in the beneficiary's home. The drug or biological product must be Food and Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the beneficiary. There must be sufficient clinical evidence demonstrating the effectiveness and safety of the drug or biological product.

An injectable drug is covered if the drug is:

- Specific and effective treatment for the condition for which it is being given.
- Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient).
- Administered by the recommended or accepted administration method for the condition being treated.
- Administered according to the recommended dosing schedule and amount for the condition being treated.

For any injectable drug that a practitioner purchases directly through a pharmacy, distributor or wholesaler which is administered in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

MDHHS allows a select list of physician-administered drugs to be covered through the pharmacy benefit as identified in the Special Product Coverage section of the Pharmacy Chapter. If the practitioner uses a pharmacy to acquire the drug for administration, the pharmacy must submit the claim as a pharmacy claim. (Refer to the Special Product Coverage section of the Pharmacy chapter for additional information.)

If the beneficiary has other insurance that allows the injectable drug product to be obtained at the pharmacy by the beneficiary, then the other insurance rules (e.g., Medicare Part D) must be followed; however, the reimbursement of the beneficiary's liability (i.e., coinsurance/deductible/ copay) may be covered as a physician service.

When administering a dose drawn from a multidose vial, only the amount administered to the beneficiary is covered. If a drug is only available in a single use vial and any drug not administered must be discarded, the amount of the drug contained in the vial is covered.

3.16.A.1. Off-Label Use of Physician-Administered Drugs [Subsection Added 7/1/2025]

Off-label uses of physician-administered drugs generally require a prior authorization. However, certain drug classes are protected from prior authorization requirements by state law.

Claims submitted for FDA off-label use of physician-administered drugs within the protected drug classes, as identified in MCL 400.109h, must include documentation to support the indication is evidence-based and that it is being administered within generally accepted standards of practice. This may include, but is not limited to, documents from medical compendia, peer reviewed studies, progress notes, or provider letters that demonstrate other failed lines of treatment.

Prior authorization is required for off-label uses of drugs not included in the protected drug classes.

This policy does not apply to claims for physician-administered drugs billed under the outpatient pharmacy benefit. Refer to the Pharmacy chapter of this manual for coverage requirements of physician-administered drugs billed under the pharmacy benefit. **(text added per bulletin MMP 25-12)**

3.16.B. Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans

MDHHS will maintain a list of specific Medicaid program covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP.

A list of the specific drugs covered under this policy will be maintained on the MDHHS website. The list may be modified as new drugs are approved or added to the physician-administered carve-out. No notice of changes to the list will be issued directly to providers. (Refer to the Directory Appendix for website information.)

3.16.B.1. Prior Authorization Requirements for Carve-out Injectable Drugs and Biological Products

Certain drugs on the carve-out list of physician-administered drugs and biological products not covered by MHPs may require prior authorization (PA). The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility.

When indicated on the MDHHS-maintained list, PA requests will require a completed Practitioner Special Services Prior Approval-Request/Authorization form (MSA-6544-B), a Program Review Division (PRD) documentation checklist, and all supporting documentation. Providers are to contact the PRD to obtain the PRD documentation checklist for drugs and biological products that require PA. Once all required documentation is collated, information must be submitted according to form MSA-6544-B completion and submission instructions. (Refer to the Forms Appendix for a copy of the

form and completion instructions and to the Directory Appendix for PRD contact information.)

3.16.B.2. Billing Considerations for Carve-out Injectable Drugs and Biological Products for Medicaid Health Plan Enrollees

When multiple medical services are provided in conjunction with a carve-out physician-administered drug, FFS claims will process for payment of the carve-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary's health plan for payment.

3.16.C. Administration of the Injectable

Medicaid covers the injectable drug and the administration of the drug. If the administration of the drug is an integral component of the procedure, the administration is considered a part of that service and is not separately reimbursed.

Payment for administration of injectables provided through a PIHP/CMHSP clinic or affiliated physician practice is included in the capitation rate to the PIHP/CMHSP and is not separately reimbursable to the physician.

Injections in the office/clinic/beneficiary's home may be administered by appropriate non-physician staff who are employed by the physician or are employed by the same clinic/group as the physician. Administration of the injectable drug by non-physician staff must be under the physician's personal supervision or under the delegation and supervision of the physician as required by the Public Health Code. Providers should refer to the Coordination of Benefits Chapter of this manual for additional requirements that apply when a beneficiary has Medicare or commercial insurance coverage. For a list of the drugs administered under this policy, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information. Physician-administered drugs and biologicals are included on the Practitioner and Medical Clinic Fee Schedule. (Refer to the Directory Appendix for website information.)

3.16.D. Injectables Administered Through PIHP/CMHSP for MHP Enrollees

Specific injectable drugs administered by a physician or non-physician practitioner (e.g., physician assistant and nurse practitioner) through a PIHP/CMHSP clinic to Medicaid Health Plan (MHP) enrollees are reimbursable by MDHHS on a fee-for-service basis when the following criteria are met:

- The beneficiary has an open case with the PIHP/CMHSP;
- The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/supports regimen; and
- The PIHP/CMHSP clinic notifies the beneficiary's MHP or primary care physician that this service is being rendered.

A list of the specific drugs covered under this policy is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) The list may be modified as new drugs are approved for Medicaid coverage. No notice of changes to the list will be issued directly to providers. Drugs on this list may be billed using the provider's NPI number(s) associated with the PIHP/CMHSP.

3.16.E. Psychotropic Injectables Administered by Physicians Not Associated With a PIHP/CMHSP

Physicians not associated with a PIHP/CMHSP who are administering psychotropic injectable carve-out drugs in an outpatient setting to MHP enrollees must comply with the following criteria:

- Physicians administering psychotropic injectable carve-out drugs must notify the beneficiary's MHP or primary care physician that this service is being rendered.
- Injectable carve-out drugs covered by MDHHS through FFS must be billed through CHAMPS using the physician's NPI.
- FFS reimbursement by MDHHS to physicians not associated with a PIHP/CMHSP is limited to psychotropic injectable carve-out drugs only. Physicians may not bill MDHHS for additional services rendered during the visit, including any injectable administration cost. Physicians should bill the MHP for any additional services, if necessary, after obtaining MHP prior authorization as per the "Out-of-Network Services" policy located in the Medicaid Health Plan chapter.

3.17 Laboratory

Medicaid covers diagnostic laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury and a limited number of screening laboratory tests, including but not limited to, those associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF).

Covered laboratory and pathology services must be:

- Recommended and ordered by the beneficiary's treating physician, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM according to their scope of practice.
- Provided in accordance with evidence based generally accepted standards of medical practice.
- Clinically appropriate in terms of type, frequency, extent, site, and duration for the beneficiary's symptoms, diagnosis, illness, or injury.
- Used in the clinical management of the beneficiary's specific medical condition.
- Provided in accordance with all applicable Medicaid clinical criteria, requirements, policies, and/or provisions of coverage.
- Performed in a laboratory appropriately certified by the Clinical Laboratory Improvement Amendments (CLIA).

Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements.

3.17.A. Medical Necessity

The beneficiary's medical record must include sufficient documentation to support the medical necessity of the laboratory service regardless of where the tests are performed. The documentation must include a description of the beneficiary's symptomatology and other findings that led the practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

3.17.B. Referred Services

If a practitioner refers a beneficiary to an outside laboratory (e.g. independent clinical lab or hospital outreach lab) for testing, the practitioner must indicate their NPI number on the referral. A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office (i.e., skin lesions, pap smears, etc.) for analysis.

3.17.C. Practitioner's Office Laboratory

Medicaid covers laboratory services provided in a practitioner's office laboratory (POL) when they are appropriate to be performed in the office and the POL is certified to perform the specialties or subspecialties of tests billed. The laboratory must hold a CLIA certificate of registration, compliance (COC), accreditation (COA), waiver (COW) or a certificate of Physician Performed Microscopy Procedures (PPMP) from the Centers for Medicare & Medicaid Services (CMS). The POL's CLIA number must be present on the claim for laboratory services to be considered for reimbursement. POL reimbursement is limited to services listed on the applicable provider's fee schedule.

3.18 Nerve Block

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area are covered within a six-month period without documentation of medical necessity. Documentation must include the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.

3.19 Orthoptic Services

Strabismus surgeries are covered for beneficiaries of any age and do not require PA. Providers are reminded that these surgeries must be medically necessary and not performed solely for cosmetic purposes.

Refer to the Vision chapter of this manual for other specific orthoptic coverages.

3.20 Oxygen

Medicaid covers oxygen and the equipment necessary for the administration of oxygen therapy.

A pharmacy or a medical supplier may provide gaseous cylinder oxygen. Portable cylinder oxygen is allowable if the cylinder can be refilled and if the flow rate is adjustable.

Only a medical supplier may provide concentrators, liquid oxygen, and oxygen tents, and PA is required.

All oxygen and equipment requires a physician's prescription and a CMN. The initial prescription is valid for six months. The first follow-up prescription is valid for six months, and each subsequent prescription is valid for one year.

The written prescription for oxygen must include all of the following:

- The date the oxygen was prescribed;
- The beneficiary's diagnosis(es);
- The flow rate (liters per minute);
- The number of hours to be used per day;
- Duration of need;
- Delivery system to be used; and
- PO2 level or oxygen saturation.

(Refer to the Medical Supplier Chapter of this manual for additional information related to face-to-face and PA requirements.)

3.21 Substitute and Locum Tenens Physicians

Medicaid covers substitute physicians or locum tenens physicians and allows payment to be made to the beneficiary's regular physician for these services. Federal statutes and CMS requirements determine parameters for these arrangements.

Medicaid coverage under the beneficiary's regular physician for the services of a substitute physician can only occur under the following substitute physician billing arrangements:

- An informal reciprocal arrangement for a period not to exceed 14 days; or
- A locum tenens or temporary arrangement for 90 continuous days in the case of a per diem or other fee-for-time compensation.

Coverage for services provided by a substitute physician under either a reciprocal billing or a locum tenens arrangement must follow Medicaid policy for the service(s) rendered. Documentation in the beneficiary's medical record must identify the physician actually providing the service.

3.22 Supplies in the Office Setting

RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the practitioner in connection with the service, and the supplies are not separately reimbursed.

Providers must not require beneficiaries to purchase an item in advance from a pharmacy or medical supplier that is an integral component of the service. Surgical dressings applied by a physician in the office or other nonfacility setting are not covered separately.

Medicaid does not cover take-home supplies dispensed from the office setting. If a beneficiary requires in-home supplies, a written prescription must be presented to the pharmacy or medical supplier and supplies dispensed accordingly.

In keeping with the RVU-based fee schedule, Medicaid separately covers a limited number of supplies used in the office setting (such as intrauterine devices and casting supplies) because an allowance for these supplies is not typically included in the respective treatment procedure codes. Casting and splinting supplies are covered separately when used with the fracture and dislocation or casting, splinting or strapping procedure codes listed in the musculoskeletal surgery section of the CPT coding manual.

(Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding separately covered supplies.)

3.23 Tuberculosis Testing

Medicaid covers TB testing according to the guidelines established by the AAP and USPSTF which are based on risk. A risk assessment may be completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test.

For assistance in determining high risk, providers may contact the MDHHS Division of Communicable Diseases, the AAP, or the USPSTF. (Refer to the Directory Appendix for contact information.)

3.24 Vision Services

Refer to the Vision chapter of this manual for specific coverage information.

3.25 Weight Reduction

Medicaid covers a broad array of health services for the treatment of obesity. These services include, but are not limited to, physician office visits, pharmacotherapy, laboratory, behavioral health, and surgical interventions.

Gastric bypass, metabolic, and bariatric surgeries, collectively referred to as weight loss surgeries, involve modifications to the digestive system that promote weight loss. Weight loss surgery is an evidence-based treatment for obesity resulting in significant weight loss and the improvement, prevention, or resolution of many associated comorbidities including type 2 diabetes, heart disease and hypertension.

3.25.A. Coverage of Weight Loss Surgery

Weight loss surgery is a covered service for the treatment of obesity when medically indicated and when the procedure performed is within professional standards of medical practice. Covered surgical procedures may include, but are not limited to, gastric bypass, gastric band, sleeve gastrectomy, removal, revision, and/or replacement of adjustable gastric restrictive devices, and subcutaneous port components and repeat procedures. Procedures considered investigational/experimental are not covered services. Mandatory participation in a preoperative weight loss regimen prior to weight loss surgery is not required.

3.25.B. Criteria

Body Mass Index	Medically indicated weight loss surgery will be covered for the treatment of obesity in beneficiaries meeting one or more of the following criteria: ▪ A body mass index (BMI) > 40 kg/m² regardless of the presence or absence of co-morbidities; or ▪ BMI > 35 kg/m² and < 40 kg/m² with at least one co-morbid condition. Common co-morbid conditions include, but are not limited to: ➢ Coronary artery disease; ➢ Type-2 diabetes; ➢ Obstructive sleep apnea; ➢ Hypertension; or ➢ Impaired glucose tolerance (diabetes) ▪ BMI = or < 35 kg/m² when documentation supports medical necessity, including those beneficiaries who may require weight loss surgery to reduce their BMI in preparation for other medical procedures.

Beneficiaries are encouraged to have a health behavior/psychosocial assessment by a licensed mental health provider to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors that may impact the beneficiary's ability to successfully achieve the necessary post-operative treatment and healthcare requirements.

Coverage of associated medically necessary reconstructive procedures directly attributable to weight loss surgery, such as panniculectomy procedures, will be considered through the prior authorization (PA) process. Providers must obtain a separate PA for these services.

3.25.C. Prior Authorization

PA is required for weight loss surgeries. Requests must include a completed, signed, and dated MSA-6544-B – Practitioner Special Services Prior-Approval – Request/Authorization form. If submitting the prior authorization request electronically via direct data entry in the Community Health Automated Medicaid Processing System (CHAMPS), this PA

request form is not required. PA requests must include the medical history, past and current treatment and results, complications encountered, results of the health behavior/ psychosocial assessment (when indicated), and expected benefits or prognosis for the method requested.

Refer to the General Information for Providers Chapter and the Directory Appendix of this manual for additional language and webpage location of Fee-for-Service Medicaid Prior Authorization Criteria.

Refer to the Pharmacy Chapter for information regarding Medicaid coverage of pharmacotherapy for the treatment of obesity.

SECTION 4 – GENERAL PRACTICE - SPECIAL CONSIDERATIONS

4.1 APHERESIS, THERAPEUTIC

Therapeutic apheresis is covered for the following indications:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom);
- Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes;
- Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease;
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome;
- Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy;
- Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome; and
- Treatment of life-threatening Systemic Lupus Erythematosous (SLE) when conventional therapy has failed to prevent clinical deterioration

Coverage is limited to the following settings:

- In a hospital setting (either inpatient or outpatient). Nonphysician services furnished to hospital patients are covered as hospital services. When covered services are provided to hospital patients by an outside provider/supplier, the hospital is responsible for paying the provider/supplier for the services.
- In a nonhospital setting, such as a physician directed clinic, when all of the following conditions are met:
  - A physician is present to perform medical services and to respond to medical emergencies at all times during patient care hours.

- Each patient is under the care of a physician.
- All nonphysician services are furnished under the personal supervision of a physician.

When the physician provides direct supervision of the procedure or personally performs any services, professional services are covered as therapeutic apheresis (plasma and/or cell exchange).

4.2 Chemotherapy Administration

Medicaid covers the services of a physician who administers antineoplastic chemotherapy to beneficiaries with a cancer diagnosis in the office setting and in the beneficiary's home. The chemotherapy drugs administered by the physician are covered separately.

Administration of other drugs for diagnoses other than cancer is covered under therapeutic, diagnostic, or prophylactic injection/infusion services.

Chemotherapy administration by push and by infusion techniques is covered on the same day; however, only one push administration is covered on a single day.

Physicians must personally administer the drug or be present when a qualified employee of the physician administers the drug. If chemotherapy is administered without face-to-face contact between the physician and the beneficiary, the services are covered if furnished in the physician's office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment.

In the hospital setting, chemotherapy administration is only covered when the physician personally administers the drug.

Refilling and maintenance of an implantable pump or reservoir is covered. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and is not covered separately. If a special visit is made to the physician's office only for port flushing, the service is covered under the appropriate E/M code.

Hydration therapy intravenous (IV) infusion is covered as a part of the chemotherapy IV infusion service when administered simultaneously. Hydration therapy is covered separately when administered sequentially or as separate procedures. The distinct procedural service modifier should be reported with the hydration therapy code when performed sequentially.

Supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services and are not covered separately. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters for chemotherapy drugs.)

4.3 Hemodialysis and Peritoneal Dialysis

Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving outpatient and emergency dialysis.

Professional services for emergency dialysis must include an ESRD diagnosis and the "Y" Emergency Indicator.

Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declotting of shunts, dialysis training, and nonrenal-related medical services.

Self-dialysis training services provided by the physician are covered.

4.4 Home Health Care

Medicaid covers home health care subject to the requirements in this section.

Home Health services include intermittent nursing care, home health aide services, and physical therapy provided in the beneficiary's home by a Medicaid enrolled Home Health Agency (HHA). The service must be reasonable and necessary for the treatment of a specific illness, injury, or disability, and must be consistent with the nature and severity of the beneficiary's condition, particular medical need and accepted standards of medical practice. Limited services to ensure stability of beneficiaries with an established disability or frail condition, or to prevent an illness, injury or disability for women and newborns during the postpartum period are covered.

Home health is intended for beneficiaries whose conditions require intermittent rather than continuous medical/nursing care. In special instances, intensive nursing care in the home may be approved if MDHHS determines that home care is appropriate and is a cost-effective alternative to institutional care.

4.4.A. Physician Order for Care

The beneficiary's physician must order covered home health services as part of a written plan of care (POC), and must review the POC every 60 days for continuing need. A HHA should not provide home care prior to the date of the physician's order for the care. The agency must maintain a patient plan of treatment form which must be signed and dated by the physician, or a narrative summary of the POC which must have the physician's signed and dated order attached. The HHA is responsible for obtaining necessary authorization from MDHHS for special or extended care which may be provided.

For initial certification, a physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90 days prior to or 30 days after the start of care. Refer to the Face-to-Face Encounter section in the Home Health Chapter for additional information.

Home health services are not to replace the services of a physician and are not covered solely for the lack of transportation or as a convenience to the beneficiary. Home health services may be appropriate when leaving the home is medically contraindicated or special transportation or effort is required.

4.4.B. Medical Supplies and Equipment

Medical supplies, durable medical equipment, orthotic and prosthetic appliances, shoe supplies, and oxygen are covered for beneficiaries receiving services from an enrolled

HHA. The physician (MD, DO, DPM, NP, PA) must prescribe these items. (Refer to the Home Health and the Medical Supplier Chapters of this manual for specific information concerning which equipment/supplies are covered for the medical supplier and which are covered for the HHA.) Face-to-face visits and prior authorization may apply.

4.4.C. Personal Care

If beneficiaries are not in need of nursing care or physical therapy, but have a need for nonspecialized, unskilled personal care or chore services, such services are available through the MDHHS Home Help Program. The local MDHHS office should be contacted for information.

4.5 Hospice Services

Medicaid covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting. Medicaid enrolled Hospice programs are responsible for providing all physician services related to a beneficiary's terminal illness as part of its core services.

To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy.

If the physician is not familiar with Medicaid-enrolled hospices in their area, hospice names, addresses, and telephone numbers may be obtained from MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Refer to the Billing & Reimbursement for Institutional Providers and the Hospice chapters of this manual for specific requirements related to the provision of hospice services.

4.6 Implantable Infusion Pumps

Medicaid covers the refill and reprogramming of implantable infusion pumps by physicians in the physician's office. The refill kit and the electronic analysis of the pump are covered as a part of the refill and reprogramming procedure. Injectable drugs used during this procedure are covered separately in the physician's office.

4.7 Pediatric Multichannel Recordings

Multichannel recording is covered for a child under age 21 when provided in the inpatient or outpatient hospital setting by qualified personnel and interpreted by a physician. Multichannel recordings are not covered in the beneficiary's home.

A pediatric multichannel recording is a continuous and simultaneous recording of at least four channels that may include ECG, thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Other additional recording parameters may be included. A multichannel recording does not have to include an electroencephalogram (EEG). When an EEG is performed in addition to the four or more channels, it is covered separately. Payment for the multichannel recording is

the same regardless of the number of channels or the length of time required. Use of a video camera is not separately covered.

Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified for CSHCS beneficiaries, the physician must obtain PA. The PA number must be included on the claim for payment. (Refer to the General Information for Providers Chapter for additional prior authorization information.)

A multichannel recording is covered as a professional service to the physician and as a technical service to the hospital. The professional service includes the interpretation with written report, and the scanning and scoring.

4.8 Preventive Services

The program covers preventive services assigned a grade A or B by the USPSTF and all adult vaccines and their administration recommended by ACIP for beneficiaries age 21 years and older. (Refer to the Directory Appendix for USPSTF and ACIP website information.)

Vaccine counseling services, including stand-alone vaccine counseling services, are covered for all adult Medicaid beneficiaries when they are counseled regarding the importance of vaccines. Stand-alone vaccine counseling refers to when a beneficiary and/or caregiver receives counseling about a vaccine from a health care practitioner, but the beneficiary does not actually receive the vaccine on the same date of service as the counseling.

Preventive services, including vaccine counseling services, for beneficiaries under 21 years of age are covered as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.)

Providers submitting claims for services in accordance with the USPSTF grade A and B recommendations are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). To identify the service as a preventive service, providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)

SECTION 5 – EVALUATION AND MANAGEMENT SERVICES

Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the State. Providers should refer to the CPT explanations, coding conventions, and definitions for E/M services.

Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the beneficiary.

Do not report the modifier for increased procedural services with E/M services in order to request individual consideration, unless specifically directed by this manual. This does not follow CPT coding guidelines and causes longer delays in processing the claims for payment.

5.1 PREVENTIVE MEDICINE SERVICES

The program covers one preventive visit annually. For beneficiaries under 21 years of age, EPSDT screening services are covered according to the AAP periodicity schedule and CMS requirements. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.)

A preventive medicine E/M visit and another E/M visit on the same date are covered separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem oriented E/M visit. When this occurs, the office/outpatient E/M procedure code is covered using the modifier for a separately identifiable service, and the preventive E/M visit is covered without using a modifier. (Refer to CPT guidelines for additional information.)

5.2 E/M VISITS IN RELATION TO GLOBAL SURGERY PACKAGE

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the beneficiary's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If the surgeon performs E/M services during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.

5.3 Consultations

Medicaid covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient. A consultation includes preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the beneficiary. A consultant may initiate diagnostic and/or therapeutic services. If the referring provider transfers complete responsibility for treatment either orally or in writing to the consultant at the time of the request for consultation, the receiving physician's services are covered as normal E/M services rather than as a consultation.

If the referring provider transfers responsibility for the beneficiary's care to the consultant after the consultation is completed, the consultant's service is covered as a consultation. After the consulting physician assumes responsibility for the beneficiary's care, subsequent visits are covered as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is covered if one provider in a group practice requests a consultation from a physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT/HCPCS consultation codes are met. A provider's request for a consultation and the need for consultation must be documented in the beneficiary's medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in the hospital record, or a specific written request for the consultation.

Medicaid covers second opinions for surgery. The second opinion is covered as a consultation as long as all requirements for a consultation are met.

Ancillary services provided to a beneficiary in a nursing facility must be ordered by the attending physician and are not covered as consultations unless a specific request for opinion and advice is documented. Requests for services by another physician are covered as the actual service provided (e.g., nursing facility visit or eye examination).

5.4 Initial Visits

Medicaid covers one new patient visit for a physician or a group practice for the same beneficiary, regardless of the type of new patient visit billed (e.g., office visit, clinic visit, long term care visit, home visit).

5.5 Observation Care [Change Made 4/1/2025]

Medicaid covers practitioner evaluation and management services related to hospital observation care. Observation care services are a well-defined set of specific, clinically-appropriate hospital outpatient services. Professional services include the ongoing short-term treatment, assessment, and reassessment necessary to determine whether a beneficiary will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. In most cases, the decision whether to discharge a beneficiary from the hospital or to admit the beneficiary as an inpatient can be made in less than 24-48 hours. **(text deleted 4/1/2025)**

The medical record must include the following documentation:

- The order for observation care services by a Medicaid-enrolled healthcare provider;

- Progress and discharge notes completed by the rendering provider;
- The billing provider was present and personally performed the services; and
- The total length of time of the observation stay.

5.5.A. Reporting of Professional Outpatient Hospital Observation Care Services

Practitioners shall report only one observation care Current Procedural Terminology (CPT) code for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. The selected code must reflect all of the practitioner's services provided during the date of the service with the following considerations:

- If a beneficiary receives less than eight hours of observation services, the practitioner is to report only initial observation care (e.g., 99221 through 99223). Practitioners will not be reimbursed for, nor should they report, CPT codes representing same-day admission/discharge or observation care discharge day management services.
- If a beneficiary receives observation care services for a minimum of eight hours but less than 24 hours, the practitioner should report the same-day discharge code which includes both admission and discharge as part of a single service (e.g., 99234 through 99236).
- If a beneficiary begins observation services and is then discharged after more than 24 hours, the practitioner may report an observation care code (e.g., CPT codes 99221 through 99223) for the date of admission, and a hospital discharge day management service (e.g., CPT code 99238 or 99239) on the date of discharge.

Time or medical decision making (MDM) may be utilized in the selection of the level of observation care service. When using time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service (i.e., the calendar date the encounter began).

5.5.B. Special Considerations

When a beneficiary is admitted to observation status in the course of an encounter in another site of service (e.g., hospital, emergency department, practitioner office, nursing facility), all services provided by the practitioner in conjunction with that admission are considered part of the initial hospital observation care when performed on the same calendar date as the admission.

Observation care services should not be reported for monitoring that is inclusive of, or included in payment for, a surgical, diagnostic, or therapeutic procedure. For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital and observation care is not covered separately.

Observation care services and inpatient hospital services for psychiatric reasons must be authorized by the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health

Services Program (CMHSP). The PIHP/CMHSP is responsible for coverage of authorized psychiatric observation care services.

Refer to the Hospital Chapter of this manual for information regarding program coverage of facility claims for outpatient hospital observation care services.

5.6 Nursing Facility Services

Visits necessary to perform Medicare and Medicaid required assessments are covered under the appropriate E/M services involving comprehensive resident assessments.

Visits required to monitor and evaluate residents at the frequencies detailed in the coverage portion of the Nursing Facility chapter of this manual are also covered under the appropriate E/M service for subsequent nursing facility care.

Additional visits for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are only covered when documentation of the medical necessity for the visit is included on, or attached to, the claim. Documentation must include diagnoses describing the acute illness or injury; or remarks documenting the necessity for the additional visit recorded on the claim; or documentation such as notes from the visit supporting the above criteria attached to the claim. Providers may report modifier 22. Additional visits which repeatedly reflect the same chronic diagnoses and additional visits for the purpose of routine monitoring are not covered.

Refer to the Coverages portion of the Nursing Facility chapter of this manual for timeframes and additional details for required nursing facility visits.

SECTION 6 – EMERGENCY SERVICES

Medicaid covers all medically necessary emergency services. Federal statutes prohibit prior authorization (PA) for coverage of emergency services. Emergency services include covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and the services are necessary to evaluate or stabilize an emergency medical condition. All professional services must be identified as either an emergency or not an emergency.

6.1 SCREENING EXAM AND STABILIZATION IN THE EMERGENCY DEPARTMENT

MDHHS and its contracted health plans must follow the applicable requirements and definitions of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Medicaid covers the medical screening examination, any ancillary service(s) when performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the beneficiary's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are covered by MDHHS. For Medicaid MHP beneficiaries, these services are covered by the beneficiary's MHP.

Professional services for the medical screening and stabilization in the ED are covered separately from the facility fees.

6.2 TREATMENT OF EMERGENCY MEDICAL CONDITION IN THE EMERGENCY DEPARTMENT

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the federal Balanced Budget Act of 1997 and its regulations.

An emergency medical condition may exist whether the beneficiary is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the beneficiary's medical record.

6.3 NON-EMERGENCY MEDICAL CONDITIONS IN THE EMERGENCY DEPARTMENT

If the medical findings from the screening indicate the beneficiary's condition does not meet the definition of an emergency medical condition, but requires additional, follow-up treatment, the following rules apply:

- FFS Medicaid beneficiaries without private health insurance should be referred to their primary care provider to obtain treatment. However, treatment may be rendered in the ED and does not require PA.

- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurers frequently require that the primary care provider perform the follow-up care.
- MHP enrollees must be referred to their primary care provider for treatment, or the MHP can be contacted to request authorization to provide the treatment. If the MHP fails to respond within one hour to the request to provide additional services beyond those required for stabilization, the request for authorization is deemed approved.

6.4 Psychiatric Emergency Services in the Emergency Department

Screening and stabilization of a psychiatric emergency does not require PA. These services are covered in the same manner as other emergency services provided in the ED detailed above. If it is determined that the beneficiary requires post-stabilization psychiatric services, the PIHP/CMHSP must be contacted for PA. The need for PA from the PIHP/CMHSP includes, but is not limited to, inpatient psychiatric admission, psychiatric partial hospitalization, and specialty mental health services.

A psychiatric emergency is defined as a situation in which an individual must be treated to protect them from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability, or could reasonably be expected to intentionally or unintentionally injure themself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for them or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

6.5 Urgent Care Settings

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital are covered. Coverage is based on the appropriate office or other outpatient services E/M procedure codes. Coverage for any additional professional services rendered in these settings follows CPT guidelines.

SECTION 7 – MATERNITY CARE AND DELIVERY SERVICES

Medicaid covers maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetrical package. The global obstetrical package is covered when one physician or physician group practice provides the obstetric care to a beneficiary. The global obstetrical package is covered as long as the provider or group has provided seven or more antepartum visits, the delivery, and the postpartum care. If less than seven antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

7.1 ANTEPARTUM CARE

Includes the initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Typically, if a beneficiary enrolls in the first trimester and delivers at term, they have about 13 antepartum visits. This varies depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

7.2 DELIVERY

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, and delivery. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the beneficiary is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery is covered separately as an E/M code. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

7.3 POSTPARTUM

Includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the beneficiary's overall obstetrical care.

7.4 OBSTETRICAL PACKAGE VS. COMPONENTS

If the same physician or group practice does not provide all of the obstetric care, Medicaid covers the portion of the care provided by each provider. Postpartum care or antepartum care is covered separately if provided by a different physician or group than the physician providing the delivery services. To be consistent with some commercial payers and Medicare, the physician or group providing the entire global obstetrical package may choose to report either the entire global package or may report the antepartum care, delivery, and postpartum care separately as each of these services is provided. Combinations of these components must be allowable under Medicaid NCCI editing. Components such as the antepartum care or postpartum care cannot be unbundled into individual visits.

Services that are not included in the global package include:

- Maternal or fetal echography or fetal echography procedures
- Fetal biophysical profile
- Chorionic villus sampling, any method
- Fetal contraction stress test
- Fetal nonstress test
- Hospital and observation care visits for premature labor (prior to 36 weeks gestation)

7.5 High-Risk Pregnancy

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetrical package. If beneficiary visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetrical package. Medicaid follows CPT guidelines for reporting high-risk pregnancy services.

7.6 Multiple Gestation

In the case of multiple gestation, Medicaid covers the services provided. Payment follows the multiple procedure rules. (Refer to the Billing & Reimbursement for Professionals Chapter, Maternity Care Services subsection, for additional information.) Providers must use a diagnosis code representing multiple gestation.

7.7 OB Enhanced Payments

MDHHS provides an enhanced payment for each Medicaid delivery performed. This additional reimbursement is added to the fee reimbursed under FFS for the global maternity and delivery procedure codes. The maternity case rate paid to MHPs is also enhanced.

7.8 Maternity Outpatient Medical Services Program

Under the Maternity Outpatient Medical Services (MOMS) program, pregnant women can enroll and receive pregnancy related care early in the pregnancy. Refer to the MOMS Chapter for additional information.

7.9 Lactation Support Services

Medicaid will reimburse for evidence-based lactation support services provided to Medicaid eligible post-partum women in the outpatient setting up to and through 12 months post-delivery. Services must be rendered by a licensed, qualified health professional as outlined. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.

7.9.A. Provider Criteria

Lactation support and counseling services must be rendered by an Internationally Board Certified Lactation Consultant (IBCLC) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) with possession of a valid and current IBCLC certification.

Rendering IBCLC providers must be Medicaid-enrolled physicians, physician assistants or advanced practice registered nurses. When a Medicaid-enrolled practitioner provides delegation and supervision within the confines of their scope of practice to an individual with possession of a valid and current IBCLC certification, that Medicaid-enrolled health professional may bill for comprehensive lactation support services.

For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the supervising physician or employing organization, where applicable, in accordance with the record keeping requirements of the Medicaid program.

7.9.B. Covered Supports and Services

Comprehensive lactation counseling services must include the following:

- A face-to-face encounter, provided in-person or via simultaneous audio-visual technology, with the beneficiary lasting a minimum of 30 minutes.
- Comprehensive maternal, infant and feeding assessment related to lactation.
- Provision of evidence-based interventions that, at a minimum, include:
  - Instruction in positioning techniques and proper latching to the breast;
  - Counseling in nutritive suckling and swallowing, milk production and release, frequency of feedings, and reasons to contact a health care professional; and
  - The provision of community support resource referrals, such as the Women, Infants, and Children (WIC) program, as indicated.
- Evaluation of outcomes from interventions.

Documentation must include a begin time and end time of services and a comprehensive description of the professional interventions provided. Documentation may be subject to review and post-payment audit.

Prenatal lactation education and support services are provided as part of the curriculum of childbirth education programs and will not be separately reimbursed. Reimbursement for lactation education and support received by beneficiaries post-delivery in the inpatient hospital is included in the inpatient hospital payment and will not be separately reimbursed.

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.

7.10 Maternal Infant Health Program

Maternal Infant Health Program (MIHP) provides preventive health services that are delivered by certified MIHP agencies to high-risk pregnant women and infants born to high risk mothers. The purpose of MIHP is to reduce infant morbidity and mortality. The goal is to deliver a healthy, full term infant. Refer to the Maternal Infant Health Program Chapter for additional information about this program.

7.11 Doula Services

MDHHS certified doulas typically provide non-clinical physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods. Evidence indicates doula services are associated with improved birth outcomes. Refer to the Doula Services Chapter for additional information.

7.12 Centering Pregnancy™

Group prenatal care is a service delivery model provided to pregnant individuals. Groups are facilitated by a trained healthcare provider and include individuals in similar stages of pregnancy. Group prenatal care models improve patient education and skill building and include opportunities for peer social support while maintaining the risk screening and physical assessment included in the individual prenatal maternity professional visit.

7.12.A. Covered Services

The Medicaid program will cover professional services associated with in-person, group prenatal care when delivered by accredited Centering Pregnancy™ providers. Centering Pregnancy™ is an evidence-based group prenatal care model that typically includes cohorts of 10 to 12 pregnant individuals within the same gestational period. Individuals are educated in health topics such as childbirth preparation, nutrition and exercise, stress management, breastfeeding, parenting, and contraception.

7.12.B. Provider Criteria

Collaborative group sessions are led by a Medicaid-enrolled physician, physician assistant, or advanced practice registered nurse. This practitioner is generally the same practitioner who performs the in-person individual prenatal physical assessment.

Sites must be accredited with the Centering Healthcare Institute (CHI). Services must be provided in accordance with the most current Centering Pregnancy™ model of care.

Refer to the Billing & Reimbursement for Professionals chapter of this manual for additional billing information.

Refer to the Federally Qualified Health Centers chapter of this manual for additional billing guidance for services provided within the FQHC.

SECTION 8 – PHARMACY

A practitioner must report their individual National Provider Identifier (NPI) with a prescription order. An emergency room practitioner must report their individual NPI with a prescription order. Each practitioner at a teaching hospital must report their individual NPI with a prescription order that is submitted to the dispensing pharmacy. A prescription or prescription order must comply with state and federal laws.

Refer to the Pharmacy Chapter of this manual for additional information.

SECTION 9 – RADIOLOGY, RADIATION THERAPY AND NUCLEAR MEDICINE

9.1 RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

Medically necessary radiological services are covered when ordered by a qualified practitioner to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic imaging services and therapeutic radiology services such as proton beam therapy, nuclear medicine, computed tomography (CT) procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other diagnostic and therapeutic services. Practitioners are required to perform or interpret radiologic services within their professional expertise and education within the confines of federal and State law. It is the expectation that practitioners conform with professional practice parameters and technical standards to ensure the most efficacious use of radiology and the delivery of safe, quality care. Medical need for all services must be documented in the medical record and is subject to post-payment review.

9.1.A. GLOBAL/COMPONENT SERVICES

Global services are covered for the physician or qualified healthcare provider in non-facility settings or the professional component is covered for the provider in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

When a physician or qualified healthcare provider reports a global procedure, the provider is responsible for the overall performance and quality of the test. The provider must either personally perform the test or it must be performed under a physician's supervision and direction when applicable. The provider must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of a supervising physician on the premises, other procedures dictate that a physician be present and may even need to be directly involved in the performance of the procedure.

Interpretation of radiology services are covered for any physician or qualified healthcare provider trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record. Review of results and explanation to the beneficiary are part of the attending provider's E/M service and are not considered as interpretation of the study.

9.1.B. MULTIPLE SERVICES ON SAME DAY

Medicaid covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use a bilateral code when available. Medicaid also covers multiple studies of both areas if reported with the appropriate modifier. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.

9.2 Specific Radiologic Services

9.2.A. CT, MRI, PET Scans

For CT, MRI and PET scans to be covered, all conditions of Certificate of Need (CON) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results.

Radiographic images, including CT or MRI studies of the same anatomical area, are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myelogram may be covered on the same day; however, an MRI and a myelogram are not covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day, and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem.

CT and MRI scans may be done with or without contrast media or both. When a scan is done without contrast followed by another with contrast, only the full service is covered. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media.

In certain instances, the use of low osmolar contrast media (LOCM) is separately covered. In the case of intra-arterial and intravenous radiological procedures, LOCM is covered separately for nonhospital patients with one or more of the following:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting;
- A history of asthma or allergy;
- Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;
- Generalized severe debilitation; or
- Sickle cell disease.

If the patient does not meet any of these criteria, the contrast media is considered bundled into the global service and is not covered separately.

When high dose contrast technique is used with MRI, the global service is covered for the procedure designated without contrast, then with contrast. The third MRI (again with contrast) is not covered separately. The contrast material used in the second MRI procedure is not covered separately; however, the contrast material for the third MRI procedure is covered separately.

9.2.B. Contiguous Areas

Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.

9.2.C. Obstetrical Ultrasound

Obstetrical ultrasound studies are covered in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The need for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections. The use of ultrasound studies for routine fetal age determination in or preparatory for pregnancy termination procedures is considered part of the termination procedure and is not covered separately.

9.2.D. Screening Mammography

Screening mammography, including clinically indicated digital breast tomosynthesis, is covered for individuals in accordance with current, evidence-based, generally accepted standards of medical practice. A practitioner referral or order is not required.

9.2.E. Transrectal or Prostate Ultrasound

Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.

9.3 Radiation Therapy

Medicaid covers medically necessary radiation therapy services provided to beneficiaries. CPT/HCPCS guidelines for radiation therapy services are followed.

Following the Medicare guidelines, many services are bundled into the treatment management codes and are not covered separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management service:

- Anesthesia
- Care of infected skin
- Checking treatment charts
- Continuing-care patient evaluation and examination
- Final medical examination
- Nutritional counseling

- Pain management
- Medical prescription
- Review and revision of the treatment plan
- Routine medical management of related problems
- Special care of ostomy
- Verification of dosage
- Written reports, progress notes
- Follow-up examination and care 90 days after the last treatment

Medicaid separately covers services furnished by a radiation physicist only when provided to a nonhospital beneficiary in a freestanding facility.

Professional services provided to hospital patients are covered only when personally performed by a physician.

Global physician services are only covered if provided in a freestanding, nonhospital setting.

9.4 Nuclear Medicine

Medicaid covers medically necessary nuclear medicine procedures. Providers are responsible for complying with Federal and State law requirements. Only professional services rendered to hospital patients are covered for the practitioner.

Medicaid covers global services when provided in a freestanding, nonhospital setting. Radionuclides used in the procedures are covered separately.

When specific nuclear medicine diagnostic procedures are performed, multiple procedure coverage rules apply. Generation and interpretation of automated data is covered as a part of the primary procedure.

9.5 Transportation and Set-Up of Portable X-ray Equipment

The transportation of portable x-ray equipment, set-up, and personnel may be covered when furnished in a place or residence used as the patient's home, including a nursing facility, as reported by the corresponding HCPCS code. (Refer to the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapters of this manual for additional information.)

SECTION 10 – HOSPITAL INPATIENT PHYSICIAN SERVICES

Medicaid covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section.

10.1 VENTILATION MANAGEMENT

Ventilation management provided in the inpatient hospital setting is covered separately unless an E/M service is provided on the same day.

10.2 CRITICAL CARE

Medicaid covers critical care consistent with the CPT/HCPCS definitions and guidelines. Each day that critical care is provided, the medical record must support the level of service provided. The actual time spent with the patient delivering critical care services must be documented in the medical record.

10.3 RESPIRATORY CARE

Medicaid covers respiratory care as a separate service in the inpatient hospital setting for the anesthesiologist/physician who initiates respiratory care by setting up the respirator, placing the beneficiary on the respirator, and providing daily supervision of the beneficiary for the respiratory care alone.

10.4 STANDBY SERVICES

Medicaid does not cover the services of a standby surgeon, anesthesiologist or surgical team. Only direct beneficiary care is covered. Physician standby services are covered as a part of the hospital services.

SECTION 11 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

11.1 GLOBAL SURGERY

Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.

11.1.A. SERVICES INCLUDED IN THE GLOBAL SURGERY PACKAGE

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries.
- Intra-operative services that are a usual and necessary part of a surgical procedure.
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.
- Follow-up visits within the post-operative period related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies for certain services furnished in a physician's office.
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

11.1.B. SERVICES NOT INCLUDED IN THE GLOBAL SURGERY PACKAGE

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery.
- The office or hospital visit to decide upon surgery if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care. (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records.)
- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.

- Clearly distinct surgical procedures that are not repeat procedures, or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.
- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&Cs global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.
- When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

11.2 Partial Global Package

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

Surgeons should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. MDHHS assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum. The modifier for post-operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. Surgeons must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the beneficiary's medical record.

11.3 Bilateral Surgery

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral". The RVUs for these codes reflect the work involved if done bilaterally as the description states. Other procedure code descriptions do not include bilateral but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

Reimbursement for a bilateral procedure reported appropriately with modifier 50 is based on the lower of the amount billed or 150 percent of the fee screen for the procedure.

11.4 Multiple Surgical Procedures

Multiple surgeries are separate procedures performed by a physician on the same beneficiary during the same operative session or on the same day for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. MDHHS follows CMS multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as a part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. Medicaid reimburses up to 100 percent of the fee screen for the most complex surgical procedure and up to 50 percent of the fee screens for the second through the fifth surgical procedures. If more than five multiple procedures are performed, an operative report must be provided with the claim.

11.5 Multiple Endoscopy Procedures

Multiple endoscopy procedures are reimbursed based on the full fee for the highest paid service, plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the coverage for the related endoscopies as one service, and any other unrelated endoscopy or procedure as another service.

11.6 Multiple Surgeons

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same beneficiary during the same operative session. This may be required due to the complex nature of the procedures or the beneficiary's condition. Medicaid reimbursement policy is based on CMS guidelines for Medicare services for multiple surgeons.

11.7 Co-Surgeons

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure is reimbursed at the full screen times 62.5 percent. Second and subsequent services are paid at 50 percent of the full-allowed amount times 62.5 percent.

11.8 Team Surgeons

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement is based on individual consideration.

11.9 Assistant at Surgery/Assistant Surgeon

Medicaid covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services is not allowed when co-surgeons or team surgeons are utilized.

Medicaid does not cover assistant surgeon services in a teaching hospital setting unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. The surgical procedure is reported with appropriate modifier identifying use of an assistant surgeon.

Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant (PA), a certified nurse practitioner (NP), a certified clinical nurse specialist (CNS) and, in limited instances, a certified nurse midwife (CNM). PA, NP, CNS and CNM services as assistant at surgery must be under the delegation and supervision of the physician employing the PA, NP, CNS or CNM, or a physician employed by the same group practice that employs the PA, NP, CNS or CNM. If the PA, NP, CNS and/or CNM are employees of the hospital, their services are covered as a part of the hospital charges.

11.10 Surgeons Performing Distinctly Different Unrelated Procedures

If two or more physicians each perform distinctly different, unrelated surgeries on the beneficiary on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, the multiple procedures modifier should not be used unless one of the surgeons individually performs multiple surgeries.

11.11 Vision Procedures and Care

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must report the surgical care only modifier with the surgery procedure code. This includes the pre-operative care, the surgery, and any in-hospital post-operative

care. Post-operative care after hospital discharge is covered separately for the provider that the care was transferred to using the surgery code with the post-operative management only modifier.

Surgical procedure descriptions that include the phrase "one or more sessions" include all sessions. These procedures include the 90-day global period during which the procedure(s) can be completed in one or more session(s). These procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more sessions are included. Separate coverage for a second or subsequent session of the same procedure during the global period of the initial service is limited to cases where the modifier reported with the procedure code indicates that services were performed on different eyes.

SECTION 12 – SURGERY - SPECIAL CONSIDERATIONS

12.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions.

Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections.

The medical record must include a complete beneficiary history, including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

12.2 BREAST RECONSTRUCTION SURGERY

Medicaid covers breast reconstruction surgery following the diagnosis and treatment of breast cancer. Covered services include procedures related to the affected and the contralateral unaffected breast following a medically necessary mastectomy. The prior authorization requirements for these specified breast reconstruction procedure codes are waived when billed with appropriate ICD breast cancer diagnosis codes. The specified CPT codes subject to this PA waiver are identified in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

12.3 Cosmetic Surgery

Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:

- The condition interferes with employment.
- It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
- It is a component of a program of reconstructive surgery for congenital deformity or trauma.
- It contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the PA request.

Physicians should refer to the General Information for Providers Chapter for specific information for obtaining authorization.

12.4 Destruction of Lesions

Medicaid covers destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery.

Coverage of the surgical destruction of lesions that involves more extensive procedures is limited to the hospital/facility setting. Less extensive procedures are covered in the office/non-facility setting. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding which procedures require a hospital/facility setting for coverage and which procedures are covered in the office/non-facility setting.) If a repeat procedure to the same lesion is necessary, it is covered as an office visit.

Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit.

12.5 Hysterectomy

Hysterectomies are covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render them permanently incapable of reproducing. The beneficiary or their representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) serves as the written acknowledgment.

All items on the MSA-2218 must be completed and the form must be signed by the beneficiary (or representative) and the physician (MD or DO).

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.

12.5.A. Exceptions

The MSA-2218 is not required in the following situations:

- The beneficiary was already sterile before the hysterectomy.
- The beneficiary requires a hysterectomy because of a life-threatening emergency situation. It was not possible for the physician to inform the beneficiary in advance that the surgery would make them permanently incapable of reproducing.
- The hysterectomy (as covered according to Medicaid policy) was performed during a period of retroactive eligibility.

12.5.B. Acknowledgement of Receipt of Hysterectomy Information

Providers may attach a copy of the MSA-2218 to the claim or submit the MSA-2218 via fax.

Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

(Refer to the Forms Appendix for a copy of MSA-2218. The form is also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

12.5.C. Procedure for Acknowledgement of Receipt of Hysterectomy Information Approval

- The provider who obtains the required Acknowledgement completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to the Medicaid Payments Division, Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

12.6 Organ Transplants

Medicaid covers organ transplants and related services if all requirements for these services are met. PA is required for all beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants.

Refer to the Hospital Chapter for further information.

12.7 Sterilization

Medicaid covers sterilization procedures when specific requirements are met. Medicaid defines a sterilization procedure as any medical procedure, treatment, or operation for the purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687).

Sterilizations are only covered if all of the following are met:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified (e.g., diagnosis, physician's statement, or hospital summary). The nature of the emergency must be included on the consent form.

12.7.A. Informed Consent Process

The following procedures must be included in the process of informed consent:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days after the MSA-1959/HHS-687 is signed, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary may have concerning the procedure.
- Suitable arrangements must be made to ensure that information is effectively communicated to the deaf, blind, or otherwise handicapped.
- An interpreter must be provided if the beneficiary does not understand the language used on the consent form or the language used by the person obtaining informed consent.
- The beneficiary is permitted to have a witness of their choice present when informed consent is obtained.
- At the time of the informed consent, a copy of the consent form must be given to the beneficiary.

All of the following sterilization information and advice must be presented orally to the beneficiary both at the time the beneficiary signs the MSA-1959/HHS-687 and again by the physician performing the sterilization shortly before the procedure (e.g., during the pre-operative examination):

- Advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.

The beneficiary, the person who obtained the consent, and the interpreter (if required) must sign the MSA-1959/HHS-687 not less than 30 days nor more than 180 days prior to the sterilization. The physician performing the sterilization must also sign and date the MSA-1959/HHS-687 after the sterilization has been performed.

No additional reimbursement is allowed for the examination or the sterilization explanation.

If the procedure occurs in a place other than that in which the consent form is signed (e.g., forms were signed in the physician's office, but the procedure will be rendered in the hospital), the person obtaining consent must send a copy of the completed form to the place of surgery. The second provider (e.g., hospital) is responsible for acquiring the physician's statement (if not previously documented) and for photocopying the signed form and supplying copies to any other Medicaid provider who is billing as a participant in the sterilization.

A copy of the completed MSA-1959/HHS-687 is required for coverage of charges related to a sterilization procedure. This form may be faxed or attached to the claim form.

12.7.B. Consent for Sterilization Form

Providers may attach a copy of the Consent for Sterilization (MSA-1959/HHS-687) form to the claim or submit the MSA-1959/HHS-687 via fax.

Federal regulations require that this form be submitted to MDHHS before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and pre-confirms the acceptability of the completed consent form.

(Refer to the Forms Appendix for a copy of MSA-1959/HHS-687. Refer to the Directory Appendix for website and contact information.)

12.7.C. Procedure for Consent for Sterilization Form Approval

- The provider who obtains the required Consent and completed MSA-1959/HHS-687 completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet (according to Document Management Portal instructions) and completed MSA-1959/HHS-687 to the Medicaid Payments Division, Sterilization Consent Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The MSA-1959/HHS-687 is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the MSA-1959/HHS-687 has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- Providers may then submit claims (either electronic or hard copy) to Medicaid. The remarks section or appropriate electronic segment must include the statement "Consent on File."
- When sterilization claims are received with this information in the remarks section, consent form edit requirements are forced if the submitted invoice matches the consent form on file.

- If there is no response within five working days:
  - Confirm that the fax is working.
  - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
  - Resend the information if necessary.

12.7.D. Reversal of Sterilization

Services to reverse a previous sterilization are not covered by Medicaid.

SECTION 13 – DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETICS

Refer to the Medical Supplier Chapter of this manual for additional information.

SECTION 14 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

14.1 BEHAVIORAL HEALTH SERVICES

Medicaid covers behavioral health services for diagnostic or active treatment purposes. Behavioral health services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.) For services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through Medicaid Health Plans or FFS Medicaid. Under FFS, behavioral health services may be provided by a physician (MD or DO), psychologist, social worker, professional counselor, or marriage and family therapist (as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix). (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding covered services.)

Beneficiaries enrolled in an MHP will receive behavioral health services through the health plan. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)

(Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for services covered by the PIHPs/CMHSPs and authorization requirements.)

Psychological Testing	Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's mental or developmental status and strengths and needs. If a beneficiary requires psychological testing more than once per year, documentation of medical necessity must be maintained in the medical record. Psychological testing must be ordered by a physician (MD or DO) and may be performed by a psychologist who is fully licensed, limited-licensed, or temporary limited-licensed. This order must be kept in the beneficiary's clinical record. Supervision of limited-licensed and temporary limited-licensed psychologists must comply with the requirements of Michigan Public Act 368 of 1978, as amended.
Inpatient Psychiatric Admissions	Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state owned, is limited to eligible beneficiaries under age 21, and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, they would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following their 21st birthday, coverage terminates on the discharge date. All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

Psychiatric Partial Hospitalization	Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist. All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

14.2 Substance Use Disorder Services

Most substance use disorder (SUD) services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services. All providers are encouraged to utilize this system when and wherever possible.

14.2.A. Acute Care Detoxification

Acute detoxification services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries.

Admission to the acute care setting for a diagnosis of substance use must meet at least one of the following criteria as reflected in the physician's orders and patient care plans:

- Vital signs, extreme and unstable
- Uncontrolled hypertension, extreme and unstable
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment
- Convulsions or multiple convulsions within the last 72 hours
- Unconsciousness
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus
- Insulin treated diabetes complicated by diabetic ketoacidosis
- Suspected diagnosis of closed head injury based on trauma injury
- Congestive heart disease or ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence
- Active presentation of psychotic symptoms reflecting an emergent/urgent condition

14.2.B. Medication-Assisted Treatment

MAT is the use of medications often used in combination with counseling and behavioral therapies to provide a whole-patient approach to the treatment of substance use disorders (SUDs). Medications used in MAT are approved by the Food and Drug Administration (FDA). MAT programs are clinically driven and tailored to meet each patient's needs. For additional information regarding MAT, refer to the Medication-Assisted Treatment (MAT) subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter.

14.2.C. Primary Care Office-Based Substance Use Treatment (OBSUT)

OBSUT services may be reimbursed directly by MDHHS or through the Medicaid Health Plans (MHP) when provided to MHP enrollees and Fee for Service (FFS) beneficiaries based upon their enrollment. Primary healthcare providers (which encompasses the following healthcare providers: Physicians [MD/DO], Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Certified Nurse Midwives, Obstetricians/Gynecologists, and Pediatricians) in an office-based setting who are licensed or otherwise trained to provide SUD services and behavioral health providers (Licensed Psychologist [doctoral level], Licensed Social Worker [master's level], Licensed Marriage and Family Therapist [master's or doctoral level], Licensed Professional Counselor [master's or doctoral level], Limited Licensed Psychologist [master's or doctoral educational level] under the supervision of an enrolled, fully-licensed psychologist [except as noted in Section 333.18223 of the Public Health Code] who are associated with them, and who do not have a specialty SUD benefit services contract with a PIHP) may be reimbursed through the Medicaid FFS program or through the MHPs. OBSUT services provided by qualified providers, as identified above, will be considered for reimbursement through the FFS program or through the MHPs when the beneficiary meets the American Society of Addiction Medicine (ASAM) criteria for outpatient treatment.

Providers are required to provide services consistent with clinical practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and ASAM.

The following services related to substance use treatment will qualify for FFS or MHP reimbursement when a beneficiary meets ASAM criteria for outpatient treatment and has a primary diagnosis of substance use disorder (use, abuse and dependence) as classified by the International Classification of Diseases, Version 10 (ICD-10):

- Evaluation and Management services
- Consultation services
- Psychotherapy services
- Psychiatric Collaborative Care Management services
- Behavioral Health Care Management
- Screening, Brief Intervention and Referral to Treatment (SBIRT)

- Medications for substance use treatment

Substance use treatment requires a multi-faceted and individualized approach to reach full treatment potential that may include screening and assessment, medications and medication management, and counseling and/or other psychosocial supports.

To reach optimal treatment, beneficiaries must be actively involved in their treatment and, as such, it is important that all providers coordinate care. Beneficiaries with significant substance use disorder may require assistance with transportation, housing, job resources, and other important life aspects that impact a beneficiary's recovery. Primary healthcare providers must ensure beneficiaries have access and receive referral to PIHPs for further assessment and treatment, and any of the other supports and services that are available (i.e., PIHP specialty services, community-based services, and natural supports) as needed to ensure desired treatment results.

PIHPs/CMHSPs, FFS and MHPs must partner as needed in overseeing and coordinating the treatment plan, knowing that office-based substance use treatment may be only part of the services necessary to achieve successful outcomes.

When making a referral to a PIHP, primary healthcare providers must communicate with the PIHP who is receiving the call to let them know they are about to transfer the beneficiary. The PIHP team should be supplied with the relevant background information and should have the necessary expertise to assist the beneficiary. Primary healthcare providers agree to track referrals and conduct further outreach if necessary.

Participating providers must observe applicable State and Federal laws, rules, regulations, and policies, including Michigan Automated Prescription System (MAPS) prescribing requirements. Refer to the Directory Appendix for website information regarding MAPS.

(Refer to the General Information for Providers Chapter for additional information on enrollment in CHAMPS.)

14.2.D. Additional Substance Use Disorder Services

Medicaid covers additional substance use disorder services through capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for coverage details and authorization requirements.)

14.3 Psychiatric Collaborative Care Model (CoCM) Services

14.3.A. General Information

CoCM is a model of integrated behavioral health service which is typically provided within the primary care setting. The evidence-based model includes a person-centered care team, weekly and/or monthly monitoring of person-centered goals, and referral to behavioral health support services if goals are unmet after an initial six-month episode of care. CoCM uses team-based collaborative and management services which are provided under the direction and supervision of a treating physician or other qualified healthcare

professional and utilizes a measurement-based treatment-to-target approach. The CoCM team includes the primary care provider, a behavioral health care manager, a psychiatric consultant and the FFS or MHP beneficiary. The model requires the use and maintenance of a patient registry, typically maintained by the behavioral health care manager, which is to be accessible by the primary care provider and psychiatric consultant. CoCM allows for behavioral health integration services to be delivered in a familiar setting that helps engage beneficiaries in care, adapts to their changing needs over time, and reduces the likelihood of duplication of services by addressing both physical and behavioral health care in one setting.

14.3.B. Target Population

CoCM is intended for beneficiaries who typically have behavioral signs and/or symptoms of a newly diagnosed behavioral health condition, need help engaging in treatment, have not responded to care delivered in a non-psychiatric setting or require further assessment, engagement and management prior to consideration of a referral to a psychiatric care setting.

These services are not intended to manage severe and/or persistent conditions which require specialty care. Eligible conditions include, but are not limited to, mild to moderate depression, anxiety, bipolar disorder, attention deficit disorder, substance use disorder (SUD), and individuals who may not be deemed eligible for specialty services through CMHSP.

14.3.C. Psychiatric Collaborative Care Model

Medicaid enrolled providers must be able to demonstrate they are following the evidence-based best practices of CoCM. The model is most effective when all five core principles are in place and incorporated into service delivery. These principles include:

- **Person-centered care:** The beneficiary is part of the team and makes the ultimate decisions regarding their treatment and based on their own goals.
- **Measurement-based treatment-to-target strategy:** The use of validated tools allows measurement of beneficiary signs and symptoms.
- **Population-based care:** The patient registry allows monitoring of beneficiary outcomes by the care team over time and can be utilized in conjunction with, or alongside, existing beneficiary health records.
- **Evidence-based treatment:** Beneficiaries are offered evidence-based treatment that may include medications and brief therapeutic interventions.
- **Accountable care:** The CoCM team of providers is accountable for all beneficiary care, including quality and clinical outcomes for beneficiaries receiving CoCM support services.

14.3.C.1. Episode of Care

An episode of care begins when a beneficiary starts CoCM and an episode of care ends when a beneficiary either:

- Fulfills treatment goals and the beneficiary returns to usual primary care follow-up;
- Fails to attain treatment goals, fails to improve or their condition worsens and requires referral to specialty services, or
- A break in services for six consecutive months or more occurs, at which point a new episode of care begins.

14.3.C.2. Measurement-Based Treatment to Target Strategy

The model utilizes validated tools which allows for measurement of beneficiary signs and symptoms. At a minimum, the POC for each beneficiary should be adjusted every 10-12 weeks based on the goal of reducing measured symptoms. Outcome measures are tracked in a patient registry. For example, if a beneficiary is recommended to engage in evidence-based therapy and does not exhibit symptom measurement improvement after 10 weeks, the psychiatric consultant may recommend an adjustment to treatment in an effort to reach person-centered goals.

14.3.C.3. Required Documentation

CoCM is a data-driven service delivery model that requires the use of a patient registry and corresponding POC for each beneficiary. The registry can be part of, or maintained alongside, an already existing Electronic Health Record (EHR). Typically, the behavioral health care manager is responsible for maintaining these tools and ensuring all documentation is included. CoCM services are most effective when the psychiatric consultant has direct access. Documentation must support the services provided and follow Medicaid documentation requirements, including consent for treatment. Services must be provided within the confines of state and federal law. Behavioral health care managers are required to ensure all aspects of registry/POC are included in the documentation.

Documentation requirements, at a minimum:

- Beneficiary information,
- Assessment, treatment plan, including evidence-based treatment interventions,
- Monitoring of individual beneficiary progress,
- Referrals, and
- Medication management.

The patient registry, at a minimum, must include the following key components:

- Date of enrollment and date of most recent contact with care team,
- Initial and most recent validated outcome measure,
- Prompt treatment-to-target strategies for treatment adjustment according to changes in validated tool scores, such as a flagging/alert system or systematic weekly review of the patient registry, and
- Facilitation of efficient, systematic psychiatric caseload review.

14.3.D. Collaborative Care Team Criteria

All team members must participate in the care and treatment of the beneficiary to be considered as a covered CoCM service. Services are reported by the primary care provider and include the services of the treating physician, behavioral health care manager and the psychiatric consultant who is contracted to provide consultative services to the primary care provider. Psychiatric consultants typically make recommendations to the behavioral health care manager who will then convey recommendations to the treating physician. The psychiatric consultant does not typically provide direct consultation to the treating physician or direct treatment to beneficiaries, but instead works through the behavioral health care manager.

Primary Care Provider or Treating Physician	A licensed Medicaid-enrolled health care provider (e.g., MD/DO, certified Nurse Practitioner [NP], certified Clinical Nurse Specialist [CNS], Physician Assistant [PA]), who will: ▪ Direct the behavioral health care manager, ▪ Continue to provide and direct beneficiary behavioral health and physical care, ▪ Prescribe and manage medications based on psychiatric consultant recommendations, and ▪ Make referrals to specialty care as needed.
Behavioral Health Care Manager	A licensed master's or doctoral level clinician, or individual with specialized training in behavioral health (such as a licensed social worker, registered nurse, or licensed psychologist) working under the direction and supervision of the primary care provider, who will: ▪ Provide care management services through face-to-face and non-face-to-face interactions, ▪ Assess beneficiary needs, ▪ Develop a POC, ▪ Administer validated screening tools (PHQ-9 or GAD-7) at least monthly, or more frequently if clinically indicated, ▪ Provide evidence-based interventions, ▪ Engage in ongoing collaboration with the primary care provider, ▪ Maintain the patient registry, and ▪ Consult weekly with the psychiatric consultant (may be non-face-to-face).

Psychiatric Consultant	Medical professional (MD, DO or Mental Health Nurse Practitioner [MHNP])) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will: ▪ Recommend treatment strategies, ▪ Recommend medication and changes in medication based on beneficiary status, ▪ Recommend referral to specialty services when needed, ▪ Consult weekly with the behavioral health care manager, ▪ Consult with and advise the treating primary care provider as clinically indicated, ▪ Have infrequent contact with beneficiaries (refer to the Reimbursement subsection within the Psychiatric Collaborative Care Model [CoCM] Services subsection of this chapter for additional information), and ▪ On rare occasions, directly prescribe medications to a beneficiary.
Beneficiary	The beneficiary is an active member of the care team and participation in care has proven to increase motivation, adherence to treatment plan, satisfaction with care and positive beneficiary outcomes.

14.3.E. Coverage of CoCM Services

CoCM is a covered service for beneficiaries who are diagnosed with a psychiatric disorder that requires behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and brief interventions. For primary medical care practices that meet all CoCM team criteria, Medicaid will cover CoCM services provided by the care team and rendered by the primary care provider for six months of care. After the initial 12 months, prior authorization is required for 12 additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs after the initial six months or their condition worsens, the beneficiary is to be referred to specialty services. An episode of care does not have to be six consecutive months. A beneficiary can be absent from services for five months and still return to their initial episode of care. After a six-month break in service, a new episode of care begins and prior authorization is not required.

CoCM services are based on reaching person-centered goals through the planning and management of the behavioral health care manager and primary care provider all in consultation with the psychiatric consultant.

CoCM services must include:

- **Initial assessment:** Visit occurring either in-person or via audio-visual telemedicine in which the beneficiary sets goals and is screened by a diagnosis-appropriate and consistent validated clinical rating scale, such as the PHQ-9 or GAD-7, which also must be done prior to subsequent CoCM services.
- **Continued monitoring:** Face-to-face or non-face-to-face weekly to monthly follow-up by the behavioral health care manager that must include monthly screening with validated rating scale, monitoring of goals and/or medication, and may include recommended evidence-based therapies.

- **Monthly monitoring:** Continues until goals are met, the beneficiary stops participating or the beneficiary is referred to specialty services.

14.3.F. Non-covered Services

Psychiatric CoCM services do not include:

- Treatment related to severe and persistent behavioral health conditions that require specialty care beyond the intent of CoCM services.
- Direct interaction between the beneficiary and the psychiatric consultant, either in person or by telephone. CoCM services typically include the psychiatric consultant as recommending treatment to the behavioral health care manager and are ultimately directed by the primary care provider.
- SUD-related Medication Assisted Treatment (MAT) is not covered under CoCM services and should be reported separately.

14.3.G. Prior Authorization

After the initial 12 months of care, prior authorization is required for an additional 12 months. Prior authorization requests must include documentation showing progress toward beneficiary goals through validated screening tool scores and an explanation for the medical necessity of continued services. (Refer to the Prior Authorization subsection of this chapter for additional information.)

14.3.H. Reimbursement

CoCM is a bundled monthly payment that represents a model of care rendered by all team members. The primary care provider is the sole biller for CoCM and services are not to be billed by the psychiatric consultant. The primary care provider agency is expected to have its own contract with the psychiatric consultant and will pay for their services as part of the CoCM. Providers are expected to adhere to the American Medical Association's CPT coding guidelines for Psychiatric Collaborative Care Management Services.

Direct consultant services delivered to beneficiaries by the psychiatric consultant outside of CoCM, such as evaluation and management or therapeutic interventions, may be reported separately.

To avoid duplication of services, CoCM services should not be provided to beneficiaries receiving the following Medicaid program services:

- MI Care Team benefit,
- Behavioral Health Home benefit,
- Substance Use Disorder Health Home benefit, or
- Other care management services that include mental health treatment.

Providers may check the beneficiary's assigned benefit plan information in CHAMPS.

14.3.I. Federally Qualified Health Center and Rural Health Clinic Reimbursement

CoCM services provided by a FQHC or RHC provider (e.g., MD/DO, certified NP, certified CNS, PA) do not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System.

14.3.J. Indian Health Center Reimbursement

CoCM services provided by a Tribal Health Center (THC) or Tribal Federally Qualified Health Center (FQHC) provider (e.g., MD/DO, certified NP, certified CNS, PA) do not qualify as an encounter. It may, however, be reimbursed outside of the All Inclusive Rate (AIR).

14.3.K. Substance Use Disorder CoCM Reimbursement

For MHP-enrolled beneficiaries, CoCM services provided for a primary diagnosis of SUD are carved-out of the MHPs. Such services will be reimbursed by the PIHPs, or FFS as applicable, per Medicaid policy.

SECTION 15 – PRIVATE DUTY NURSING

Refer to the Private Duty Nursing Chapter of this manual for additional information.

SECTION 16 – OUTPATIENT THERAPY

Refer to the Therapy Services Chapter of this manual for additional information.

SECTION 17 – TELEMEDICINE

Refer to the Telemedicine chapter for additional information.

SECTION 18 – ANESTHESIOLOGIST ASSISTANT

Medicaid covers anesthesia services provided by qualified anesthesiologist assistants (AAs). AA services are covered for the AA or for the entity with which the AA has an employment or contract relationship that provides for payment to be made to the entity.

For specific coverage parameters, refer to the Anesthesia Services section of this chapter.

To enroll as a Medicaid provider, an AA must meet all of the following requirements:

- Works under the delegation and direction of a Medicaid enrolled anesthesiologist.
- Is in compliance with all applicable requirements of State law.
- Is a graduate of a medical (MD or DO) school-based anesthesiologist assistant education program that:
  - Is accredited by the Committee on Allied Health Education and Accreditation; and
  - Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.
- Is currently certified by the National Commission for Certification of Anesthesiologist Assistants.

SECTION 19 – CERTIFIED REGISTERED NURSE ANESTHETIST

Medicaid covers anesthesia and analgesia services provided by a Medicaid enrolled Certified Registered Nurse Anesthetist (CRNA).

19.1 COVERED SERVICES

CRNAs must comply with Michigan scope of practice licensing laws and regulations and State law requirements for supervision, as applicable. Supervising providers (physicians, dentists, and podiatrists) must be Medicaid enrolled providers. Pain management services provided by a CRNA in a freestanding pain clinic may only be covered when provided under the supervision of a Medicaid enrolled physician.

CRNA services are covered for the CRNA or for the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to the entity.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, the CRNA costs are included in the facility payments to the hospital and are not covered separately by Medicaid.

For specific coverage parameters, refer to the Anesthesia Services Section of this chapter. Refer to the Billing & Reimbursement for Professionals Chapter for information regarding Anesthesia modifiers. Refer to the Practitioner Reimbursement Appendix for information regarding the payment calculation of anesthesia services.

19.2 ENROLLMENT

To enroll as a Medicaid provider, a CRNA must meet all of the following requirements:

- be currently licensed in Michigan as a registered professional nurse;
- be certified by the State as a CRNA; and
- complete an on-line application through the CHAMPS Provider Enrollment subsystem.

(Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional enrollment information, and the Directory Appendix for contact information.)

SECTION 20 – CERTIFIED NURSE PRACTITIONER

Medicaid covers services provided by qualified Medicaid enrolled nurse practitioners (NPs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.

20.1 COVERED SERVICES

Medicaid covers medically necessary services provided by a NP, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met:

- the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law with the NP specialty certification granted by the Michigan Board of Nursing;
- the NP is legally authorized to perform the service in compliance with state law;
- the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

NP services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for NPs. Professional services are only covered when the NP has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the NP and physician are covered for a single practitioner only.

20.2 ENROLLMENT OF NURSE PRACTITIONERS

A NP who provides professional services to Medicaid beneficiaries is required to be a Medicaid-enrolled provider and uniquely identified on claims. To enroll as a Medicaid provider, the NP must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider.

20.2.A. RENDERING/SERVICING-ONLY PROVIDER

A physician-employed NP who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. They may enroll as a Rendering/Servicing-Only Provider, and payment for services will be made to the employing, supervising physician or physician group.

20.2.B. Individual/Sole Provider

NPs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each MHP.

During enrollment and enrollment revalidation processes, the NP must report the NPI of their Medicaid enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the NP. To avoid interruption in enrollment, the NP must ensure their CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

20.3 Nurse Practitioner Collaborative Practice Agreement

As part of the enrollment and enrollment revalidation processes, the NP must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided.

The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The NP must maintain the collaborative practice agreement at their primary place of practice and provide the agreement to MDHHS upon request.

The terms of the agreement, at a minimum, must include the following:

- A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan;
- A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available;
- A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;
- A provision that allows the practitioner or collaborating physician to terminate their agreement; and
- The signatures of the practitioner and physician.

The NP must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the NP from the program.

20.4 Nurse Practitioner Billing and Reimbursement

Professional claims must include the NPI of the NP in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information.

Fee-for-Service reimbursement for NP services is based upon the limits and rates associated to physician professional services and are published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on an NP functioning as an assistant at surgery.)

SECTION 21 – CERTIFIED CLINICAL NURSE SPECIALIST

Medicaid covers services provided by qualified Medicaid enrolled clinical nurse specialists (CNSs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.

21.1 COVERED SERVICES

Medicaid covers medically necessary professional services provided by a CNS, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met:

- the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law, with the CNS specialty certification granted by the Michigan Board of Nursing;
- the CNS is legally authorized to perform the service in compliance with state law;
- the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

CNS services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for CNSs. Professional services are only covered when the CNS has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNS and physician are covered for a single practitioner only.

21.2 ENROLLMENT OF CLINICAL NURSE SPECIALISTS

The CNS who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNS must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider.

21.2.A. RENDERING/SERVICING-ONLY PROVIDER

A physician-employed CNS who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. They may enroll as a Rendering/Servicing Only Provider, and payment for services will be made to the employing, supervising physician or physician group.

21.2.B. Individual/Sole Provider

CNSs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in an MHP, the CNS must negotiate provider terms and payment arrangements with each MHP.

During enrollment and enrollment revalidation processes, the CNS must report the NPI of their Medicaid-enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the CNS. To avoid interruption in enrollment, the CNS must ensure their CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

21.3 Collaborative Practice Agreement

As part of the enrollment process, the CNS must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided.

The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The CNS must maintain the collaborative practice agreement at their primary place of practice and provide the agreement to MDHHS upon request.

The terms of the agreement, at a minimum, must include the following:

- A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan;
- A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available;
- A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;
- A provision that allows the practitioner or collaborating physician to terminate their agreement; and
- The signatures of the practitioner and physician.

The CNS must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the CNS from the program.

21.4 BILLING & REIMBURSEMENT

Professional claims must include the NPI of the CNS in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional information.

Fee-for-Service reimbursement for CNS services is based upon the limits and rates associated to physician professional services and is published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on a CNS functioning as an assistant at surgery.)

SECTION 22 – CERTIFIED NURSE MIDWIFE

Medicaid covers services provided by qualified Medicaid enrolled certified nurse midwives (CNMs). (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.)

22.1 COVERED SERVICES

Medicaid covers medically necessary professional services provided by a CNM, as defined in Public Act 368 of 1978 as amended, when all the following requirements are met:

- the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law, with the CNM specialty certification granted by the Michigan Board of Nursing;
- the CNM is legally authorized to perform the service in compliance with state law; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

Covered services include those within the CNM's scope of practice as defined in state law. Services focus on inpatient and outpatient obstetric, gynecologic and women's primary health care. Services must be administered within the framework of an alliance agreement that provides for physician consultation and referral as indicated by the health of the beneficiary. Covered CNM services include the following:

- Maternity care, including antepartum care, hospital delivery and postpartum care;
- Newborn care;
- Primary care services for women throughout their lifespan, including physical exams;
- Diagnosis and treatment of common health problems;
- Gynecological services;
- Reproductive health services;
- Contraceptive services;
- Treatment of male partners for sexually transmitted infection and reproductive health; and
- The prescribing of pharmacological and nonpharmacological interventions and treatments that are within the CNM's specialty role, scope of practice, and state law.

22.2 MATERNITY CARE

Medicaid covers antepartum care, delivery, and postpartum care rendered by a CNM when provided in compliance with Medicaid policy.

Antepartum Care	Coverage for antepartum care includes all usual and customary antepartum services provided prior to delivery and referral to MIHP when there are psychosocial or nutritional factors that could adversely affect the pregnancy or the health and well-being of the mother or infant. If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by multiple CNMs or physicians within a group practice, the antepartum care package may be covered. (Refer to the Maternity Care and Delivery Services Section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.
Delivery	Deliveries performed by a CNM are covered in a licensed hospital setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes the usual and customary services associated with the hospital admission, management of labor, monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary.
Post-partum Care	Medicaid covers usual and customary inpatient and outpatient post-partum services provided after the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether they performed the delivery. (Refer to the Services to Newborns subsection in this chapter for additional coverage information.)

22.3 Office Visits

Visits not directly related to antepartum care or follow-up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters. Refer to the Evaluation and Management Services Section of this chapter for specific coverage information related to office visits.)

22.4 Enrollment of Certified Nurse Midwives

The CNM who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNM must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI). Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

Practitioners who wish to provide services to Medicaid Health Plan (MHP) enrollees are encouraged to contact the individual MHP for additional enrollment, credentialing, and contract requirements.

22.5 Billing & Reimbursement

Professional claims must include the NPI of the CNM in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information.

Professional services are only covered when the CNM has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNM and physician are covered for a single practitioner only.

Fee-for-Service reimbursement for CNM services is based upon the limits and rates associated to physician professional services and are published on the CNM fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for its services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on a CNM functioning as an assistant at surgery.)

SECTION 23 – PHYSICIAN ASSISTANT

Medicaid covers physician assistant (PA) services provided by qualified, Medicaid enrolled practitioners in conjunction with covered surgeries and other procedures. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool available through CHAMPS for more information regarding coverage parameters. (Refer to the Directory Appendix for CHAMPS access information.)

23.1 COVERED SERVICES

Medicaid covers medically necessary services provided by a PA, as defined in Public Act 368 of 1978 as amended, when all the following requirements are met:

- the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as a PA under state law;
- the PA is legally authorized to perform the service in compliance with state law;
- the services are performed under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

23.2 ENROLLMENT OF PHYSICIAN ASSISTANTS

PAs who provide professional services to Medicaid beneficiaries are required to be enrolled providers in the Medicaid program and uniquely identified on claims for their services to be considered eligible for reimbursement. To enroll, the PA must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) as a Rendering/Servicing-Only provider. Additional provider enrollment information can be found on the MDHHS website and in the General Information for Providers Chapter of this manual. (Refer to the Directory Appendix for website information.)

23.2.A. PARTICIPATING PHYSICIAN

Professional services rendered by a PA will be covered when provided under the terms of a valid practice agreement established with a participating physician as defined in state law. A group of physicians practicing other than as sole practitioners may designate one or more physicians in the group to enter into a practice agreement.

During enrollment and enrollment revalidation, the PA must report the NPI of their Medicaid-enrolled participating physician by including the participating physician's NPI on the checklist and associating to the participating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the participating physician from the program may prompt disenrollment of the PA. To avoid interruption in enrollment, the PA must ensure their CHAMPS enrollment information reflects current/accurate participating physician information.

Practitioners who wish to provide services to Medicaid Health Plan (MHP) enrollees are encouraged to contact the individual MHP for additional enrollment, credentialing, and contract requirements.

23.2.B. Practice Agreement

As part of the enrollment process, the PA must attest to having a valid practice agreement with a participating physician that complies with applicable state law requirements. Determination of medical necessity and appropriateness of services is the responsibility of the PA and participating physician based on the terms of the practice agreement. The participating physician does not have to be physically on the premises where the services are provided. The PA shall maintain the practice agreement at their primary place of practice and provide the agreement to MDHHS upon request.

23.3 Billing & Reimbursement

23.3.A. Claims

Professional claims must include the NPI of the PA in the Rendering Provider field and the participating or supervising physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information.

23.3.B. Reimbursement

As a Rendering/Servicing-Only provider, PAs are not eligible to receive direct reimbursement. Payment for PA services will be issued to the participating physician, physician group or billing provider. Professional services are only covered when the PA has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the PA and physician are covered for a single practitioner only.

Fee-for-Service reimbursement for PA services is based upon the limits and rates associated to physician professional services and are published on the Practitioner fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapter for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP.

Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements.

(Refer to the Surgery - General section of this chapter for information on a PA functioning as an assistant at surgery.)

SECTION 24 – PHYSICAL THERAPIST

Refer to the Therapy Services Chapter for additional therapy information.

SECTION 25 – PODIATRIST

Medicaid covers the medically necessary services of a podiatrist. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.)

Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

25.1 COPAYMENT

A copayment is required for each separately covered visit for beneficiaries age 21 and older. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one copayment is required. If a procedure such as a surgery with a global period is rendered, only one copayment is required. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

25.2 CONSULTATIONS

Medicaid covers limited and intermediate level consultations if requested by a physician or qualified healthcare provider.

25.3 NURSING FACILITY SERVICES

Podiatry services provided to a beneficiary in a nursing facility are considered an ancillary service and require the written order of the beneficiary's attending physician. All terms and conditions related to Medicaid covered and non-covered services, including PA and billing requirements, apply to services provided to beneficiaries in a nursing facility.

SECTION 26 – GENETIC COUNSELORS

26.1 COVERED SERVICES

Medicaid covers medically necessary genetic counseling services, as defined in section 333.17001 (Act 368 of 1978), when provided by a licensed Genetic Counselor and ordered by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs).

Genetic counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Counseling is considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background.

Services are only covered when the genetic counselor has personally performed the genetic counseling and no other provider or entity has billed or been paid for the service. Genetic counseling services provided jointly by the genetic counselor and a collaborating physician or qualified non-physician medical practitioner are covered for a single practitioner only.

Genetic tests recommended as a result of genetic counseling may be covered when provided in accordance with Medicaid's Genetic and Molecular Testing policy. Providers should refer to the Genetic and Molecular Testing subsection of the Laboratory Chapter for information on genetic testing.

26.2 ENROLLMENT OF GENETIC COUNSELORS

Licensed genetic counselors may enroll with Medicaid for reimbursement of genetic counseling services. To enroll as a Medicaid provider, the Genetic Counselor must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider. Genetic counselors in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs (LARA) and certified by the American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics (ABMG). Out-of-state counselors must be currently licensed by the appropriate standard-setting authority in the state where they are practicing and must comply with Michigan Medicaid policy requirements regarding the provision of out-of-state services.

Individuals holding temporary genetic counselor licenses are not eligible to enroll as providers or be directly reimbursed by Medicaid. Services performed by these individuals must be performed under the supervision of a fully licensed, qualified genetic counselor as defined in section 333.6109 (Act 368 of 1978). Services must be billed to Medicaid under the NPI of the supervising genetic counselor.

Licensed genetic counselors may not be employed by or contracted with a commercial genetic testing laboratory. Genetic counselors working within an integrated, comprehensive health care delivery system that operates a laboratory but also routinely delivers health care services beyond laboratory testing are not excluded from enrollment.

PRACTITIONER REIMBURSEMENT APPENDIX

SECTION 1 – REIMBURSEMENT METHODOLOGY

1.1 PRACTITIONER FEE SCREENS

Practitioner payment rates are established by MDHHS as a fee screen for each procedure. The Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVS) and other relative value information, other state Medicaid fee screens, and providers' charges may be utilized as guidelines or references in determining the maximum fee screens for individual procedures. The Practitioner fee schedule is updated annually following the CMS January release of the RBRVS. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

Any rate discrepancies will be resolved by using the policy language describing reimbursement methodology for the established fee schedules.

1.2 ANESTHESIA SERVICES

The fee schedule rate calculation for anesthesia services (Current Procedural Terminology [CPT] codes 00100 to 01999) is, with the exceptions noted in the Anesthesia Services section of the Practitioner Chapter of this manual, based on the sum of the allowable anesthesia base units and anesthesia time units (i.e., time reported in min/15) multiplied by the State anesthesia conversion factor. Pricing modifier adjustments are then applied. Reimbursement will be the calculated fee screen or the provider's charge, whichever is less. No additional reimbursement will be made for beneficiary risk factors such as age or health status. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information about the impact of anesthesia modifiers on reimbursement.

1.3 EMERGENCY DEPARTMENT SERVICES

Physician services provided in the ED are covered as individual services. Critical care services are covered according to the CPT/HCPCS definitions and coding conventions for critical care. If critical care is required for a beneficiary in the ED, then only the critical care codes are covered. ED E/M or visit codes are not covered on the same day as critical care for the same provider.

When a beneficiary is seen in the ED, the appropriate level of ED E/M service is covered unless another E/M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E/M service which includes the medical screening exam is covered without regard to whether the medical screening results in the medical condition being deemed an emergency or not. The results of the medical screening examination, along with any medically necessary appropriate diagnostic services, determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient must be provided and are covered in addition to the ED E/M service. CPT/HCPCS coding conventions and Medicaid guidelines must be followed.

The medical record must support the need for the type and extent of diagnostic services performed based on the presenting symptoms of the beneficiary. The ED physician's review of x-rays and EKGs performed on the beneficiary are covered as a part of the E/M service. Professional component services are covered only for the physician who prepares a complete, written report of the findings for the medical

record. If a specialist in the field prepares this, then the ED physician's review of the findings does not meet the conditions for separate coverage of the service.

The ED E/M services provided by the attending physician, regardless of the level of the service, are covered using a two-tiered rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen.

The two-tiered fee screen applies only to the attending ED physician E/M service. The standard Medicaid fee screens continue to be applied to other separately billable attending ED physician services and the services of other physicians (e.g. specialists) who provide E/M or other services in the ED. When billing for these additional services, CPT/HCPCS coding conventions and Medicaid program guidelines must be followed.

1.4 Neonatal and Pediatric Critical Care Services

Effective for dates of service on and after October 1, 2022, practitioner rates for inpatient neonatal and pediatric critical and intensive care services will be reimbursed at 100% of the Medicare annual rate.

1.5 Obstetrical Services

Effective for dates of service on and after October 1, 2014, practitioner rates for obstetric care, including antepartum, delivery, and postpartum services, will be reimbursed at 95% of Medicare rates.

1.6 Psychiatric Services for Individuals <21 Years of Age

Effective for dates of service on and after February 1, 2020, practitioner rates for psychiatric diagnostic evaluation services provided to individuals less than 21 years of age will be reimbursed at 100% of the Medicare annual rate.

Effective for dates of service on and after January 1, 2021, practitioner rates for psychotherapy and other psychiatric services provided to individuals less than 21 years of age will be reimbursed at 63% of Medicare.

SECTION 2 – ENHANCED PRACTITIONER PAYMENTS

MDHHS makes payment adjustments for practitioner services payable under Medicaid Fee-For-Service (FFS) through entities identified in the Medicaid State Plan, Attachment 4.19-B, page 1a. (The Medicaid State Plan is available on the MDHHS website; refer to the Directory Appendix for website information.)

2.1 QUALIFYING PRACTITIONERS

Adjustments apply to both public and private practitioners and practitioner groups who are either employees of the public entities identified in the state plan, or are under contract with one or more of the public entities, and include the following:

- University medical and dental faculty, employed practitioners, and private practice groups with contractual arrangements with one or more of the above universities and provide services to Medicaid beneficiaries in a variety of settings.
- Hurley Hospital-employed or -contracted physicians, dentists, and other practitioners who provide services to Medicaid beneficiaries in a variety of settings.

Services eligible for the payment adjustments are billed under the federal employer identification number of the public entity or under the federal employer identification number of the practitioner/practitioner group.

Inpatient and outpatient services provided by the following practitioners, when not included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral-Maxillofacial Surgeons
- Dentists
- Podiatrists
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Anesthesiologist Assistants
- Optometrists

2.2 Payment Adjustment Amount

The payment adjustment amount for services provided to Medicaid beneficiaries who do not have other insurance coverage will be the lesser of:

- The difference between the practitioner Medicaid fee-for-service fee screen and the practitioner's customary charge; or,
- Up to 100% of the Average Commercial Rate for the service rendered.

The payment adjustment amount for services provided to Medicaid beneficiaries with other insurance coverage will be the lesser of:

- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and the practitioner's customary charge; or,
- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and up to 100% of the Average Commercial Rate.

2.3 Financing the Payment Adjustments

The public entities must certify to MDHHS that they will provide the non-federal share of the payment adjustments established by this policy. These public entities must also certify to MDHHS that the financial arrangements used to offset the non-federal share of these Medicaid payment adjustments do not violate Title XIX of the Social Security Act, §1903 Payment to States, Subsection (W) Prohibition on Use of Voluntary Contributions, and Limitation on Use of Provider-Specific Taxes to Obtain Federal Financial Participation Under Medicaid.

No additional state funds are available beyond the amount needed to pay designated providers up to the standard Medicaid fee screens for these services. The non-federal share of the Medicaid payment adjustments is supplied by the public entity through an intergovernmental transfer (IGT) to MDHHS.

2.4 Payment Adjustment Process

Upon receipt of the provider information from the public entity, MDHHS will generate a report which will include the federal employer identification numbers and utilization data for the providers affected by this policy for each covered period. The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, MDHHS will make the payment adjustment. The payment adjustments will be made for the federal employer identification number used to bill Medicaid under the FFS program. The payment adjustments will be processed quarterly. Each quarterly payment adjustment will include a reconciliation that takes into account all claims submitted to MDHHS and paid after the prior Physician Adjustor payment quarter cut-off date.

SECTION 3 – PRIMARY CARE PRACTITIONER SERVICES INCENTIVE PAYMENT

For dates of service on and after January 1, 2015, MDHHS applies an increased payment rate to enrolled providers for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine and, for dates of service on and after January 1, 2018, physicians with the specialty designation of general practice. The increase applies to a set of designated primary care services.

3.1 PROVIDER ELIGIBILITY

Physicians with primary specialty designations of family medicine, general internal medicine, pediatric medicine, and general practice may qualify as primary care practitioners for purposes of increased payment. Eligibility for this payment is limited to being board certified or board eligible in one of the three designated primary care specialties as recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists. Primary care physicians may also be determined eligible by conducting a thorough review of the physician's practice characteristics as identified through their billing history.

Physician practitioners whose CHAMPS Provider Enrollment profile information reflects that they provide specialty or subspecialty (e.g., cardiology, endocrinology, or oncology, etc.) services are not eligible for the adjusted payment. Providers with multiple subspecialties are also not eligible for the adjusted payment. Exceptions will be made for practitioners who have subspecialty practices in adolescent and geriatric medicine.

Before enhanced payments are made, MDHHS will verify that a practitioner meets the eligibility criteria which are identified as the following:

- Board Certification: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the eligible specialties and has provided applicable Board certification information will be validated by MDHHS prior to any enhanced payment.
- Board Eligible: A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the eligible specialties and has provided applicable documentation to support board eligibility status is also eligible for the enhanced payment. MDHHS will recognize physicians as board eligible for the period of time as defined by the applicable medical board following completion of their medical residency training program in one of the defined specialties.
- Review of Practice Characteristics: For non-board certified or non-board eligible primary care physicians, MDHHS will review an enrolled practitioner's billing history for the previous calendar year. At least 60 percent of the physician's codes paid by Medicaid must be for the evaluation and management (E/M) codes specified in this policy, including the preventive medicine E/M codes. This review of practice characteristics will be done by MDHHS only for providers who have self-attested by designating in their CHAMPS enrollment file that their primary specialty is one of the eligible specialties.
- Non-physician Practitioners: Nurse practitioners (NPs) and physician assistants (PAs) who provide primary care services while working in collaboration with a physician who is one of the designated primary care specialty types may be reimbursed at the enhanced rate. Claims submitted by NPs and PAs must include their own NPI as the rendering provider and the NPI of their supervising/delegating physician. If the collaborating physician has not been identified as

an eligible provider for the primary care rate, as verified by CHAMPS enrollment, services performed by the NP or PA will not receive the enhanced rate.

Practitioners delivering primary care services at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments (LHDs) are not eligible for these enhanced payments. Practitioner services in these settings are reimbursed using a payment methodology designed to reimburse those providers at cost and are made on a facility basis, not specific to the physician's services.

Practitioners who participate in the MDHHS Physician Adjustor Program are eligible for the primary care practitioner services incentive payment. For these participating providers, MDHHS calculates the Physician Adjustor Program payment adjustment consistent with the existing methodology.

Physicians with primary specialty designations of family medicine, general internal medicine, pediatric medicine, and general practice who are affiliated with Medicaid Health Plans (MHP) are eligible for the primary care practitioner rate increase as identified by their Primary Care Provider status within the MHP network.

3.2 Eligible Primary Care Services [Changes Made 4/1/2025]

Primary care practitioner services subject to the enhanced primary care rate are defined as Healthcare Common Procedure Coding System (HCPCS) codes:

- 99202 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits
- 99304 through 99318 for initial, subsequent, discharge and other nursing facility E/M services
- **(text deleted 4/1/2025)**
- 99341 through 99350 for new and established patient home E/M visits
- 99381 through 99397 for new and established patient preventive medicine services
- 99421 through 99423 for online digital E/M services
- **(text deleted 4/1/2025)**

3.3 Enhanced Rates for Primary Care

For primary care practitioners identified as eligible for the primary care rate, payment will be made on the qualified procedure codes as published in a separate fee schedule as published on the MDHHS website. The Primary Care Fee Schedule reflects rates that have been adjusted in compliance with funding levels established by state law. (Refer to the Directory Appendix for website information.)

PRIVATE DUTY NURSING

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Independent and Agency Private Duty Nurses.

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth in this manual.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from the Habilitation Supports Waiver (the Community Mental Health Services Program) and over 21 years of age, that program authorizes the PDN services.

For a Medicaid beneficiary who is not receiving services from the Habilitation Supports Waiver (the Community Mental Health Services Program), the MDHHS Program Review Division (PRD) reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.

Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Habilitation Supports Waiver, MI Choice Waiver).

1.1 DEFINITION OF PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.

1.2 Enrollment Requirements

Medicaid Enrolled Nurse (RN/LPN)	To enroll as a Medicaid provider, the nurse must meet the following criteria: ▪ Be a Registered Nurse (RN) licensed to practice in Michigan; or a Licensed Practical Nurse (LPN) licensed to practice in Michigan working under the supervision of an RN. Supervision of a Medicaid-enrolled LPN must be by an RN who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. Medicaid requires an on-site (beneficiary's home) supervisory visit by the RN of the LPN at least once every two months. The Medicaid-enrolled LPN must maintain documentation that verifies who the supervising RN is, a copy of the RN's license and documentation that supports that the RN supervisory visits were rendered. Documentation of the supervisory visit as signed by the RN must be included in the medical record. The medical record must be complete enough to allow another professional to reconstruct what transpired during the supervisory visit. ▪ Cooperate with MDHHS in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Medicaid-enrolled nurses must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.
Private Duty Nursing Agency	To enroll as a Medicaid provider, the PDN agency must meet the following criteria: ▪ Be accredited by the Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care (ACHC) as a PDN agency; or be accredited by The Joint Commission as a Home Health Agency; or be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program. ▪ If a PDN agency delivers services from more than one location (office), each location (office) must be accredited. PDN agencies are not permitted to avoid the above accreditation requirements by individually enrolling RNs or LPNs in the Medicaid Program. ▪ Cooperate with MDHHS in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Providers must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.

1.3 Provision of Private Duty Nursing

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty nursing agency, a Medicaid enrolled registered nurse (RN), or a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision.

Supervision of a Medicaid enrolled LPN must be by an RN who has at least one year of experience in any of the following areas:

- Community health nursing,
- Pediatric nursing,
- Maternal and child health nursing, or
- A similar nursing practice.

MDHHS requires an onsite supervisory visit by the supervising RN at least once every two months. The Medicaid enrolled LPN must maintain documentation that identifies the supervising RN.

If a beneficiary's services are performed exclusively by LPNs, the supervisory RN is responsible for completing a physical assessment for each beneficiary the LPN is caring for, and is required to participate in the development of the beneficiary's plan of care (POC). The above assessments and supervisory visits are not covered by Medicaid, including when provided by a home health agency.

PDN is not covered when rendered in a hospital or nursing facility, including an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or licensed adult foster care facility (AFC).

PDN is not covered when provided by an RN or LPN who is the beneficiary's spouse, legally responsible relative, stepparent, adoptive parent, legal guardian, or foster parent.

When more than one agency is authorized to provide PDN for a beneficiary, the hours rendered by each must be reported to the PRD on a monthly basis in order to permit the adjustment of authorized hours as necessary between the providers. Payment cannot be made until all utilized hours are reported. The primary agency on the case (the first agency involved) is responsible for contacting the other PDN provider(s) caring for the beneficiary to obtain the actual number of hours rendered during the preceding month, and must fax the total hours provided by each to the PRD. The authorization letter will detail all PDN providers that are caring for a beneficiary during the authorization period.

1.4 Prior Authorization

PDN services must be authorized by the PRD, before services are provided. (Refer to the Directory Appendix for contact information.) PDN services are authorized and billed in 15-minute incremental units (1 unit = 15 minutes). Prior authorization of a particular PDN provider to render services considers the following factors:

- Available third party resources.
- Beneficiary/family choice.
- Beneficiary's medical needs and age.
- The knowledge and appropriate nursing skills needed for the specific case.
- The understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN for persons with Medicaid coverage before services can begin and at regular

intervals thereafter if continued services are determined to be necessary. A copy of the form is provided in the Forms Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.) The parent or guardian signature certification on MSA-0372 may be electronically generated. Each MSA-0732 form requires a new electronic signature and date. This form is not to be used for beneficiaries enrolled in the MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.

The MSA-0732 must be submitted every time services are requested for the following situations:

- for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition;
- for continuation of services beyond the end date of the current authorization period (renewal);
- for an increase in services; or
- for a decrease in services.

Following receipt and review of the MSA-0732 and the required documentation by the PRD, a notice is sent to the PDN provider and beneficiary or primary caregiver, either approving or denying services, or requesting additional information. The provider must maintain this notice in the beneficiary's medical record. For services that are approved, the Notice of Authorization will contain the prior authorization number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the PRD.

If a beneficiary receiving PDN continues to require the services after the initial authorization period, a new MSA-0732 must be submitted along with the required documentation supporting the continued need for PDN. This request must be received by the PRD no less than 15 business days prior to the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined by the PRD and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

MDHHS will not reimburse PDN providers for services that have not been prior authorized. All forms and documentation must be completed according to the procedures provided in this chapter. If information is not provided according to policy (which includes signatures and correct information on the MSA-0732, POC and nursing assessment), requests will be returned to the provider. Authorization cannot be granted until all completed documentation is provided to MDHHS. Corrected submissions will be processed as a new request for PDN authorization and no backdating will occur.

If during an authorization period a beneficiary's condition changes warranting an increase or decrease in the number of approved units or a discontinuation of services, the provider must report the change to the PRD. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the POC. The request to increase or decrease units must be accompanied by an updated and signed POC; and documentation from the attending physician addressing the medical need if the request is for an increase in PDN units.

Often the request to begin services will be submitted by a PDN agency or individual PDN; however, a person other than the PDN provider (such as the hospital discharge planner, CSHCS case manager, physician, or physician's staff person) may submit the MSA-0732. When this is the case, the person

submitting the request must do so in consultation with the PDN agency or individual PDN who will be assuming responsibility for the care of the beneficiary.

If services are requested for more than one beneficiary in the home, a separate MSA-0732 must be completed for each beneficiary.

When a parent/guardian requests a transfer of care from one PDN provider to another, a completed MSA-0732 must be submitted to the PRD along with signed and dated documentation from the parent/guardian indicating that they are requesting a change in providers. The balance of hours authorized to a previous PDN provider will not be automatically transferred to a new provider. The new PDN provider is responsible for submitting the MSA-0732 to the PRD along with documentation from the parent/guardian requesting a new provider.

The PA number is for private duty nursing only. Any CMHSP prior authorized respite services must be billed to the authorizing CMHSP.

Other services provided in the home by community-based programs may affect the total care needs and the amount of PDN authorized. These other services must be disclosed on the MSA-0732 and documented in the POC. Although the amount of PDN authorized considers the beneficiary's medical needs and family circumstances, community-based services provided in the home are also part of this assessment. Disclosure is necessary to prevent duplication of services to allow for an accurate calculation of authorized PDN hours. Providers are advised that failure to disclose all community resources in the home may be cause for recoupment of funds.

1.4.A. Documentation Requirements

The following documentation is required for all PA requests for PDN services and must accompany the MSA-0732:

- Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their status during the previous authorization period, completed by a registered nurse.
- Nursing notes for two (2) four-day periods, including one four-day period that reflects the most current medically stable period and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition.
- Most recent updated POC signed and dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian. The POC must support the skilled nursing services requested, and contain dates inclusive of the requested authorization period.

  The POC must include:

  - Name of beneficiary and Medicaid ID number
  - Diagnosis(es)/presenting symptom(s)/condition(s)
  - Name, address, and telephone number of the ordering/managing physician
  - Frequency and duration of skilled nursing visits, and the frequency and types of skilled interventions, assessments, and judgments that pertain to and support the PDN services to be provided and billed

- Identification of technology-based medical equipment, assistive devices (and/or appliances), durable medical equipment, and supplies
- Other services being provided in the home by community-based entities that may affect the total care needs must be documented
- List of medications and pharmaceuticals (prescribed and over-the-counter)
- Statement of family strengths, capabilities, and support systems available for assisting in the provision of the PDN benefit (for renewals, submit changes only).

- If the beneficiary was hospitalized during the last authorization period, include documentation related to the PDN qualifying diagnosis/condition, i.e., all hospital discharge summaries, history and physical examination, social worker notes/assessment, consultation reports (pulmonary; ears, nose and throat [ENT]; ventilator clinic; sleep study; etc.), and emergency department reports (if emergency services were rendered during the last authorization period).
- Teaching records pertaining to the education of parents/caregivers on the child's care.
- Other documentation as requested by MDHHS.

1.4.B. Beneficiary Eligibility

Approval of the MSA-0732 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

1.4.C. Retroactive Prior Authorization

Services provided before PA is requested will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If the MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

1.5 Other Insurance

It is the responsibility of the family, private duty nursing agency, RN or LPN to assess, investigate and exhaust all commercial insurance for the beneficiary prior to billing Medicaid. A private duty nursing agency, RN, or LPN should not accept any Medicaid PDN case until it has been determined what, if any, commercial insurance a beneficiary may have.

For any Medicaid case accepted in which the beneficiary has other insurance, the provider must first follow the rules of the other insurance. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in nonpayment from Medicaid.

If a beneficiary's commercial insurance does not cover PDN, the PDN agency, RN or LPN must inform the PRD prior to billing MDHHS. (Refer to the Directory Appendix for contact information.) A copy of the letter of explanation or explanation of benefits (EOB) must be kept in the beneficiary's medical record.

Once it has been established that the commercial insurance does not cover PDN, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with the commercial insurance that PDN coverage has not changed.

(Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.6 General Eligibility Requirements

The beneficiary is eligible for PDN coverage when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the noninstitutional setting).
- The beneficiary is under the age of 21 and meets the medical criteria for PDN.
- PDN is appropriate, considering the beneficiary's health and medical care needs.
- PDN can be provided safely in the home setting.
- The beneficiary, their family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated POC that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually or more frequently as needed based on the beneficiary's medical needs.

1.7 Benefit Limitations

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. PDN is intended as a transitional benefit to support and teach family members to function as independently as possible. Authorized hours will be modified as the beneficiary's condition and living situation stabilizes or changes. A decrease in hours will occur, for example, after a child has been weaned from a ventilator or after a long term tracheostomy no longer requires frequent suctioning, etc. The benefit is not intended to supplant the caregiving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18, and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of units authorized per month includes eight hours or more of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the time authorized for the month. The caregiver has the flexibility to use the monthly-authorized units as needed during the month. Substantial alterations to the scheduled allotment of daily PDN hours due to family choice (i.e., vacations) unrelated to medical need or emergent circumstances require advance notice to the PRD. The remaining balance of authorized hours will not be increased to cover this type of utilization. Authorized time cannot be carried over from one authorization period to another.

The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded

programs (e.g., MDHHS Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

PDN providers are encouraged to work with families to assist in developing a backup plan for care of their child in the event that a PDN shift is delayed or cancelled, and the parent/guardian is unable to provide care. The parent/guardian is expected to arrange backup caregivers that they will notify, and the parent/guardian remains responsible for contacting these backup caregivers when necessary.

1.8 Service Log

If PDN is prior approved and care is initiated, a detailed log for each date of service must be maintained. The service log must be beneficiary specific, with the beneficiary's name and birth date in the header portion of the document and must clearly identify the specific time worked by each PDN in the home and for each date of service. In cases where the nurse is caring for two or more beneficiaries in the same home, a separate service log for each beneficiary must be maintained. This log must be kept in the beneficiary's record and may be documented in electronic or paper format. The medical record itself or nursing flow sheets containing other information are not considered a service log for the purposes of this policy. Failure to maintain a log or to submit this information to MDHHS upon request may result in recoupment of PDN reimbursement.

The following service log provides an example of the required fields.

(Beneficiary Name and Birth Date)						
Name	**Date of Service**	**Start Time**	**Stop Time**	**Units**	**Nurse Signature & Date**	**Parent/Caregiver Signature & Date**
(name RN/LPN)	10/06/10	8:00 a.m.	12:00 p.m.	16		
(name RN/LPN)	10/07/10	8:00 a.m.	4:20 p.m.	33		
(name RN/LPN)	10/08/10	7:45 a.m.	1:00 p.m.	21		
(name RN/LPN)	10/9/10	12:00 p.m.	5:45 p.m.	23		

PDN agencies should refer to the Billing & Reimbursement for Institutional Providers chapter for instructions on claim completion and requirements for the processing of claims. Medicaid-enrolled Registered Nurses (RN) or Licensed Practical Nurses (LPN) should refer to the Billing & Reimbursement for Professionals Chapter for instructions on claim completion and requirements for the processing of claims.

Each signature must be accompanied by a date. The date of the nurse's signature must be the same as the date of service. The date of the parent/caregiver signature should be within one week of the date of service. A claim must not be submitted before the service log is completed for those dates of service.

1.9 Clinical Record

In addition to the Service Log, the provider must maintain clinical records as detailed in the General Information for Providers Chapter of this manual. The clinical record must be sufficiently documented to

allow another professional to reconstruct what transpired during each hour of nursing service and billed to Medicaid in 15-minute incremental units.

1.10 PDN in Conjunction with Home Help or Personal Care Services

If the beneficiary receiving PDN demonstrates a need for personal care or Home Help services in addition to PDN, there must be coordination between the delivery of personal care or Home Help services and the PDN services, as well as documentation in the POC to verify there is no duplication of services.

1.11 Holidays

MDHHS allows additional reimbursement for holidays. Currently recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

1.12 Mileage

Staff mileage to the beneficiary's home is covered as a part of the PDN service and may not be billed separately.

1.13 Caring for More than One Patient at a Time

For ratios of more than two patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Children's Waiver (the Community Mental Health Services Program), Habilitation Supports Waiver (the Community Mental Health Services Program), Home and Community-Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) or the PRD. These ratios are considered exceptional cases and require prior approval.

When two Medicaid beneficiaries less than 21 years of age reside in the same home and require PDN services, one nurse will be authorized to provide care for both individuals. (The PDN rate is adjusted to accommodate this ratio.) In the event of an exceptional and emergent circumstance, a ratio of 1:1 nursing will be authorized for a limited period of time when two PDN beneficiaries reside in the same home. During this time period, PDN services must be reassessed on at least a monthly basis, documented in the POC, and submitted to the PDN authorizing entity to demonstrate the need for continuation of 1:1 nursing services. The POC must document efforts being made to wean the beneficiaries from 1:1 care.

A PDN authorized to provide services to two children at the same location may find that, at times, only one child is present to receive services. This may occur when one child is in school, at a medical appointment, hospitalized, or on a family outing. The beneficiary record must document why only one child was present to receive services, as well as the beginning and ending time of the services. (Refer to the appropriate Billing and Reimbursement chapter for billing instructions.)

1.14 Billing for Private Duty Nursing

For billing instructions, nurses should refer to the Billing & Reimbursement for Professionals Chapter of this manual and agencies should refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

SECTION 2 – CARE REQUIREMENTS

2.1 PLAN OF CARE

A written plan of care (POC) guides all services provided to the beneficiary by the PDN provider. The POC identifies and addresses the beneficiary's need for PDN. The POC and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

- Family members and the beneficiary (as appropriate to their maturity) participate in developing the POC. They are provided with accurate information and support appropriate to informed decision-making. They must give informed consent for the planned services by signing and dating the POC annually and when updating the POC as needed based on the beneficiary's medical needs.
- Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care. Services delivered in the home accommodate beneficiary/family life activities.
- The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.
- The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given their disability or illness.
- Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.
- If the services are provided by LPNs, the POC must identify the frequency of the supervisory RN visits.

The written POC must be retained in the beneficiary's medical record.

2.2 SUSPECTED ABUSE/NEGLECT

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the PDN must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

2.3 MEDICAL CRITERIA

To qualify for PDN, the beneficiary must meet the medical criteria of **either** I and III below **or** II and III below:

Medical Criteria I	**The beneficiary is dependent daily on technology-based medical equipment to sustain life.** "Dependent daily on technology-based medical equipment" means: ▪ Mechanical ventilation four or more hours per day, or assisted respiration does not automatically include ventilation through Bi-level Positive Airway Pressure (Bi-PAP) or Continuous Positive Airway Pressure (CPAP). Use of these devices to satisfy this criteria will be evaluated on a case-by-case basis; or ▪ Oral or tracheostomy suctioning 8 or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.
Medical Criteria II	**Frequent episodes of medical instability within the past three to six months,** requiring skilled nursing assessments, judgments or interventions as described in III below, due to a substantiated progressively debilitating physical disorder. ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months; ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder; ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and which are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ▪ "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required; and ▪ "Substantiated" means documented in the clinical/medical record, including the nursing notes. For beneficiaries described in II, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for PDN. Determination of continuing eligibility for PDN for beneficiaries defined in II is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below.

Medical Criteria III	**The beneficiary requires continuous skilled nursing care on a daily basis** during the time when a licensed nurse is paid to provide services. ▪ "Continuous" means at least once every three hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. ▪ Equipment needs alone do not create the need for skilled nursing services. ▪ "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.

2.4 Determining Intensity of Care and Maximum Amount of PDN

As part of determining the maximum amount of PDN a beneficiary is eligible for, their Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit

limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the time) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

* Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.

In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.

When using the Decision Guide, the following definitions apply:

- "Caregiver": legally responsible person (e.g., birth parents, adoptive parents, spouses), paid foster parents, guardian or other adults who are not legally responsible or paid to provide care but who choose to participate in providing care.
- "Full-time (F/T)": working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.
- "Part-time (P/T)": working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.
- "Significant" health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).
- "Some" health issues: one or more primary caregiver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., caregiver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).
- "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school plus transportation time. Authorization of PDN hours will not automatically be increased during breaks from school (vacations) or adjusted beyond the limits of factors I and II.

  The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such "health and related services" as necessary for the student to participate in their education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program) or when the child would typically be in school but for the parent's choice to home-school the child.

2.5 Exception Process

Because each beneficiary and their family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation, as established by the Decision Guide, must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or their primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written POC, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to their condition.

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

A temporary alteration in the beneficiary's care needs following a hospitalization, resulting in one or both of the following:	**The temporary inability of the primary caregiver(s) to provide required care as the result of one of the following:** ("Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.)
▪ A temporary increase in the intensity of required assessments, judgments, and interventions. ▪ A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs. The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.	▪ An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver's inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. ▪ The death of the primary caregiver(s) or an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days. ▪ The home environment has been determined to be unstable, as evidenced by MDHHS protective or preventive services involvement. The written POC and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary's Intensity of Care category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is three months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving the stabilized home environment.

2.6 Change in Beneficiary's Condition/PDN as a Transitional Benefit

Medicaid policy requires that the integrated POC be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes, warranting a decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDHHS will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDHHS was not notified of the change in condition.

In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.

2.7 Hospice Services

If a beneficiary receiving private duty nursing (PDN) becomes eligible for hospice, the hospice is required to notify the PRD before a claim is submitted for the services. (Refer to the Directory Appendix for contact information.)

The hospice must provide the following information on agency letterhead to the PRD.

- beneficiary name and Medicaid ID number;
- a request for a case review and approval of hospice services;
- a statement confirming that the beneficiary has been certified terminally ill with six months or less to live, signed by the hospice medical director and the beneficiary's attending physician; and
- name, e-mail address, and telephone number of the contact person.

PRD staff may request additional medical record documentation for their review. PDN authorization cannot occur unless the hospice submits the requested documentation to the PRD. If services are approved, the hospice must work with the PDN agency to develop a coordinated POC. Both the hospice and PDN staff must ensure that duplication of services does not occur. While hospice maintains the lead in coordinating the services, the PDN agency must continue to obtain prior authorization from MDHHS for the PDN services. Hospice services must be utilized to the fullest extent before PDN services will be authorized.

This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21 years old, or the MI Choice Waiver. For beneficiaries under the HSW (over 21 years old), providers should contact the beneficiary's case manager to inform them of hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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SECTION 1 – GENERAL INFORMATION

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

The PACE capitated benefit was authorized by the federal Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)

SECTION 2 – SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care

SECTION 3 – ELIGIBILITY AND ENROLLMENT

3.1 ELIGIBILITY REQUIREMENTS

To be eligible for PACE enrollment, applicants must meet the following requirements:

- Be age 55 years or older.
- Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Health and Human Services (MDHHS).)
- Reside in the PACE organization's service area.
- Be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.
- Receive a comprehensive assessment of participant needs by an interdisciplinary team.
- A determination of functional/medical eligibility based upon the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online within fourteen (14) calendar days from the date of enrollment into the PACE organization.
- Be provided timely and accurate information to support Informed Choice for all appropriate Medicaid options for Long Term Care.
- Not concurrently enrolled in the MI Choice program.
- Not concurrently enrolled in an HMO.

3.2 COMPLETION OF THE MEDICAID NURSING FACILITY LOC DETERMINATION

A PACE applicant's eligibility for coverage of nursing facility services and enrollment in the PACE organization is determined by the online application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). The PACE organization will not be reimbursed for nursing facility services rendered when the applicant is determined not to meet the LOCD criteria. Providers must submit the LOCD information into its online version no later than fourteen (14) calendar days following the start of services. Instructions and required forms related to the completion of the Medicaid Nursing Facility Level of Care Determination are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The LOCD must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The PACE organization will be held responsible for enrolling only those participants who meet the criteria outlined in this section.

The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the online version in the following situations:

- all new enrollments of Medicaid-eligible beneficiaries.
- re-enrollment of Medicaid-eligible beneficiaries.
- significant change in condition of a current PACE Medicaid-eligible beneficiary.

The online LOCD must be completed only once for each admission or readmission to the program.

3.3 Informed Choice

When a beneficiary is determined eligible for nursing facility level of care through completion of the online LOCD, they must be provided timely and accurate information to support informed choice for all appropriate Medicaid options for long-term care.

Process Guidelines available on the MDHHS website define the required process. (Refer to the Directory Appendix for website information.)

3.4 Nursing Facility Level of Care Exception Process - Exception Review

A Nursing Facility (NF) Level of Care (LOC) Exception Process is a review that is available for financially eligible beneficiaries who have demonstrated a significant level of long term care need but do not meet the LOCD. The NF LOC Exception Process is initiated when the PACE organization telephones the MDHHS designee and requests the NF LOC Exception Review on the date that the applicant was determined ineligible based on the online version of the LOCD. The NF LOC Exception criteria and information on how to request an Exception Review is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.5 Telephone Intake Guidelines

The Telephone Intake Guidelines are questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. The guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.6 Deeming Process

MDHHS may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program if, in the absence of continued coverage under the program, MDHHS determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

To be eligible for deeming, a participant must meet the following requirements:

- Participant must have been receiving PACE services for at least the past six months and no longer than one year.
- Participant no longer meets nursing facility level of care requirements.

- In the absence of continued coverage under PACE, the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

When a deemed PACE participant has been in the program for one year, the PACE organization must conduct an in-person annual reassessment to determine if the participant meets nursing facility level of care.

3.7 Enrollment and Disenrollment

PACE provider staff must submit PACE enrollment and disenrollment forms electronically within the Community Health Automated Medicaid Processing System (CHAMPS) by the end of card cut-off.

3.7.A. Enrollments

PACE providers must upload and submit the following signed enrollment materials with the electronic enrollment.

- Enrollment Agreement Benefits and Coverages
- Nursing Facility Level of Care Freedom of Choice Form
- If necessary, Durable Power of Attorney (DPOA) or guardianship documents

Once completed and all eligibility requirements have been checked, CHAMPS will assign the participant a PET code and enrollment start date.

3.7.B. Disenrollments

Voluntary	A signed disenrollment form must be uploaded to CHAMPS.
Involuntary	Once the electronic form has been completed, PACE providers will submit appropriate supporting documentation to their MDHHS contract manager. MDHHS will review and approve or deny the electronic disenrollment in CHAMPS and determine the appropriate date of disenrollment.
Death	Providers will enter the date of death with the electronic disenrollment. A completed disenrollment will end-date the corresponding PET code.

3.8 Annual Recertification

MDHHS must annually certify that PACE participants continue to meet PACE financial eligibility requirements. PACE organizations must also ensure that participants continue to meet the LOCD criteria on an ongoing basis. If the participant continues to meet the LOCD criteria, it must be demonstrated in the medical record by way of initial comprehensive assessments, reassessments and progress notes. Additional online LOCDs are not conducted for the purpose of determining ongoing LOCD eligibility.

If the PACE participant no longer meets the LOCD criteria, federal regulations may deem the participant to be eligible for the PACE program until the next annual reevaluation if, in the absence of continued coverage under PACE, the participant reasonably would be expected to again meet the nursing facility level of care criteria within the next six months.

3.9 Retrospective Review and Medicaid Recovery

At random and whenever indicated, MDHHS will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination. If the participant is found to be ineligible for PACE services, MDHHS will recover all Medicaid payments made for PACE services rendered during the period of ineligibility. The Retrospective Review process (defined in the Beneficiary Eligibility and Admission Process Section of the Nursing Facility Coverages Chapter) is applicable to PACE organizations.

3.10 Adverse Action Notice

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the organization must immediately issue an adverse action notice to the beneficiary or their authorized representative. The action notice must include all of the language of the sample letters for long term care. Copies of the letters are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

As with any benefit denial, the beneficiary may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDHHS website. (Refer to the Directory Appendix for MOAHR contact and website information.)

3.11 Nursing Facility Level of Care Process - Immediate Review Upon Issuance of an Adverse Action Notice

The MDHHS designee may conduct a Nursing Facility (NF) Level of Care (LOC) Process Immediate Review for a Medicaid pending/eligible beneficiary who was determined functionally/medically ineligible based on the online Michigan Medicaid Nursing Facility Level of Care Determination. The beneficiary, or their representative, must request an Immediate Review before noon of the first working day after the date of receipt of the notice as follows:

- The MDHHS designee will request the PACE organization to provide medical documentation by close of business of the first business day after the date the beneficiary requests an Immediate Review.
- The MDHHS designee will review the medical documentation, obtain information from the beneficiary and/or their representative, and notify the beneficiary and the provider of the determination within three business days of receipt of the medical documentation.

The beneficiary (or representative) may still request an MDHHS appeal of the Michigan Medicaid Nursing Facility Level of Care Determination. (Refer to the Directory Appendix for contact information.)

3.12 Freedom of Choice

When an applicant has been determined eligible for nursing facility level of care through completion of the online LOCD, the beneficiary must be informed of their benefit options and elect to receive services in a specific program. This election must take place prior to initiating PACE services.

The applicant (or legal representative) must be informed of the following:

- services available under PACE
- services available in other community settings, such as the MI Choice Program
- services available through Medicaid-reimbursed nursing facilities

If applicants are interested in nursing facility or MI Choice Program care, the PACE organization must provide appropriate referral information using the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. These guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-participants must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive PACE services.

A copy of the Freedom of Choice form is included with the Michigan Medicaid Nursing Facility Level of Care Determination on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.13 Applicant Appeals

3.13.A. Financial Eligibility

A determination that an applicant is not financially eligible for Medicaid is an adverse action. Applicants may appeal to MDHHS. (Refer to the Directory Appendix for contact information.)

3.13.B. Functional/Medical Eligibility

A determination that a beneficiary is not functionally/medically eligible for PACE services is an adverse action. If the beneficiary and/or representative disagrees with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.)

3.13.C. PACE Services

Noncoverage or nonpayment of services by the PACE organization for a beneficiary enrolled in PACE is an adverse action. If the beneficiary and/or representative disagrees with the noncoverage or nonpayment of services by the PACE organization, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.) The beneficiary may request

continuation of the disputed service with the understanding that they may be liable for the cost of the disputed service if the determination is not made in their favor.

3.14 Provider Appeals

A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for PACE when MDHHS proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the PACE organization disagrees with the MDHHS Adverse Action Notice, the PACE organization may appeal if their written request is received by MOAHR within 30 calendar days from the date of the MDHHS Adverse Action Notice.

Information regarding the MDHHS appeal process is available in the General Information for Providers Chapter and on the MDHHS website. (Refer to the Directory Appendix for website information.)

SECTION 4 – PACE ORGANIZATION EVALUATION CRITERIA

4.1 INITIAL APPLICATIONS

Initial applications are for applicants seeking to become a PACE organization for the first time.

A prospective PACE organization can be a not-for-profit or for profit private or public entity that is primarily engaged in providing PACE services and participates in both Medicare and Medicaid. Michigan licensure as a health care entity is not required; however, unlicensed entities may only serve Medicare and Medicaid beneficiaries. Federal regulations (42 CFR Part 460) describe administrative requirements for PACE. At a minimum, prospective entities must meet the federal requirements for PACE organizations to enroll as a Michigan Medicaid provider and complete a feasibility study. Prospective entities will not be considered if the prospective entity has active sanctions in other states, as defined in the Federal regulations (42 CFR Part 460 Subpart D).

4.1.A. LETTER OF INTENT

A prospective PACE entity must submit a letter of intent to MDHHS that includes:

- Name of organization
- Location of potential PACE center
- Service area that is being requested by county and/or zip code
- Capacity

For budget consideration, a letter of intent must be received by MDHHS prior to August 1 (14 months) in advance of the fiscal year in which the program plans to open.

If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which the letters of intent are received.

If MDHHS receives a letter of intent for a service area that is already being serviced by a PACE provider, MDHHS will begin the unmet need process. (Refer to the Unmet Need subsection in this chapter for additional information.)

Within 14 business days of receiving the letter of intent, MDHHS will send a letter to the prospective PACE entity to confirm the receipt of their letter of intent and notify the prospective PACE entity that a feasibility study must be submitted to MDHHS within 90 calendar days from the date of the letter.

4.1.B. FEASIBILITY STUDY

MDHHS will evaluate potential PACE organizations using the following criteria:

- Submission of a feasibility study that:
  - identifies the proposed service area;

- shows evidence of demand for PACE services in the proposed service area (the potential pool of PACE beneficiaries should be sufficient to have, at minimum, 125 participants);
- documents the organization's timeline for development and anticipated costs;
- identifies the anticipated source of referrals for potential beneficiaries and assesses the availability of long-term care services already in existence in the community;
- demonstrates organizational commitment to principles consistent with the PACE model;
- shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support;
- shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully;
- shows evidence that the PACE organization will either be cost neutral or save money for long-term care services provided by MDHHS in the PACE organization's service area (i.e., total Medicaid expenditures for services in the service area will not increase and may decrease);
- includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even consideration;
- shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population;
- shows evidence that the Executive (Program) Director position will be staffed with a full-time employee;
- shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed, as determined by MDHHS, to meet the needs of the PACE organization;
- shows evidence that the key positions will be staffed on-site; and
- demonstrates ability to meet state and federal PACE requirements.

Other evaluation criteria may be considered and will be available to organizations that file a letter of intent with MDHHS to become a PACE organization.

Once MDHHS has approved the prospective PACE entity's feasibility study, MDHHS will send an approval letter and the entity will have one year from the date of the letter to submit a PACE application to MDHHS and the Centers for Medicare & Medicaid Services (CMS). Prior to the submission, MDHHS will provide a State Assurance document in support of the application.

4.2 Expansion Applications

An expansion application is for existing PACE organizations that are seeking to expand.

Types of expansions include:

- A PACE organization requests to expand its geographic service area without building additional sites.
- A PACE organization requests to open another physical site in the existing geographic service area.
- A PACE organization requests to expand its geographic service area and open another physical site in the expanded area.
- A PACE organization requests to expand its current capacity.
- A PACE organization requests to expand its current building or change to a new address (does not require a Letter of Intent 14 months before fiscal year).

Expansion applications will not be accepted by MDHHS until the first CMS trial period audit has been completed with good standing and the organization is fiscally sound. A PACE organization will not be considered if the PACE organization has active sanctions, as defined in the Code of Federal regulations (42 CFR Part 460 Subpart D).

4.2.A. LETTER OF INTENT

An existing PACE provider must submit a letter of intent to MDHHS that includes:

- Name of organization
- Location of potential PACE center (if applicable)
- Service area that is being requested by county and/or zip code (if applicable)
- Capacity increase

For budget consideration, a letter of intent must be received by MDHHS prior to August 1 (14 months) in advance of the fiscal year in which the program plans to open. If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which the letters of intent are received.

Within 14 business days of receiving the letter of intent, MDHHS will send a letter to the PACE program to confirm the receipt of their letter of intent and notify the PACE program that a feasibility study must be submitted to MDHHS within 90 calendar days from the date of the letter.

4.2.B. FEASIBILITY STUDY

PACE organizations requesting an expansion must submit a feasibility study that includes:

- A PACE organization requests to expand its geographic service area without building additional sites.
  - Identifies the proposed service area
  - Shows evidence of demand for PACE services in the proposed service area
  - Documents the organization's timeline

- Identifies the anticipated source of referrals for potential participants
- Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration
- Shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the participants
- Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support
- Demonstrates the ability to meet state and federal PACE requirements
- Demonstrates organizational commitment to principles consistent with the PACE model
- Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed
- Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee
- Shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully

▪ A PACE organization requests to open another physical site in the existing geographic service area.

- Identifies the proposed service area
- Shows evidence of demand for PACE services in the proposed service area
- Documents the organization's timeline for development and anticipated costs
- Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration
- Shows evidence that the key positions will be staffed on-site
- Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed
- Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee
- Demonstrates the ability to meet state and federal PACE requirements
- Demonstrates organizational commitment to principles consistent with the PACE model
- Demonstrates that the organization has the depth in leadership and experience required to develop and implement PACE successfully

- Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support

- A PACE organization requests to expand its geographic service area and open another physical site in the expanded area.
  - Identifies the proposed service area
  - Shows evidence of demand for PACE services in the proposed service area
  - Documents the organization's timeline for development and anticipated costs
  - Identifies the anticipated source of referrals for potential participants
  - Includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration
  - Shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the participants
  - Shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support
  - Demonstrates the ability to meet state and federal PACE requirements
  - Demonstrates organizational commitment to principles consistent with the PACE model
  - Shows evidence that the key positions of Executive Director, Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed
  - Shows evidence that the Executive (Program) Director position will be staffed with a full-time employee
  - Shows evidence that the key positions will be staffed on-site
  - Shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully
- A PACE organization requests to increase its current capacity.
  - Identifies current capacity
  - Identifies current enrollment
  - Includes proposal for why increase is needed
  - Documents physical capacity determined by fire marshal for
    - Building
    - Day Center
    - Clinic
  - Identifies current average daily attendance for participants and staff
    - Building

- Day Center
- Clinic

➢ Documents projected daily attendance for participants and staff

- Building
- Day Center
- Clinic

▪ A PACE organization requests to expand its current building or change of address.

➢ Identifies information that will be available to organizations that file a letter of intent with MDHHS.

Other evaluation criteria may be considered and will be available to organizations that file a letter of intent with MDHHS to become a PACE organization.

Once MDHHS has approved the PACE program's feasibility study, MDHHS will send an approval letter and the PACE program will have one year from date of the letter to submit a PACE application to MDHHS and CMS. Prior to the submission, MDHHS will provide a State Assurance document in support of the application.

4.3 Alternative Care Settings

To be eligible to request an ACS, the following guidelines must be met:

- The PACE organization must have successfully completed their first trial period audit and be in good standing with CMS, per CMS audits.
- An ACS participant must belong to a PACE organizations center.
- The PACE organization's enrollment limit must have adequate space to accommodate projected ACS attendants.
- MDHHS must tour the proposed ACS location prior to approval.
- The ACS must be less than one (1) hour travel time from PACE Center.

The ACS is subject to MDHHS Readiness Review and will be included in the PACE organization's annual audits. ACSs are also subject to all state and federal regulations.

The following documents must be submitted to MDHHS when an ACS is requested:

- Previous year's annual financial report for the PACE organization;
- The PACE organization's business plan for ACS;
- Financial projection for ACS site (to include cost of ACS site, renovations, staff, equipment, etc.);
- Description of what population of participants will attend the ACS;
- Description of what and how services will be provided at the ACS:

➢ ACS services must include, but are not limited to, meals, activities, personal care, laundry, and nursing (triage);

- Description of how services that are not provided at the ACS will be available to participants; and
- Description of plan for participants to attend a PACE Center, at least quarterly or more often, as determined by the PACE organization interdisciplinary team.

MDHHS may request additional information when necessary.

4.4 Unmet Need

Definition	An unmet need is established when the number of true potential PACE beneficiaries (TPPB) is greater than zero.
Methodology	Data from the Michigan Department of Health and Human Services (MDHHS) Data Warehouse will be used to determine unmet need when a prospective PACE entity is requesting an area being served by an existing PACE organization. MDHHS will pull the following data on a quarterly basis: ▪ The number of beneficiaries in each county with an active Level of Care Determination (LOCD) and the number of beneficiaries currently in a PACE organization within each county. ▪ To determine if there is unmet need, MDHHS will multiply the number of beneficiaries with an active LOCD by 11.25%. ▪ MDHHS will remove current PACE beneficiaries and subtract the remaining enrollment capacity assigned to the current PACE organization to find the TPPB. ▪ If the number of TPPB is greater than zero, there is an unmet need; if not, the need is met. The National PACE Association (NPA) indicates 9% as the average national PACE market penetration rate (MPR). This rate is defined as the percentage of dual Medicare and Medicaid and Medicaid-only eligible beneficiaries needing long-term services and supports (LTSS) in the service area of a PACE organization who are enrolled in PACE according to the NPA. While the NPA indicates 9% as the MPR, MDHHS will use a higher MPR than the national average. Number of beneficiaries who meet nursing facility level of care times 11.25% (MPR) = number of potential PACE beneficiaries (PPB) Number of (PPB) minus current PACE organization capacity = number of (TPPB) Numerical example: 5,000 beneficiaries who meet nursing facility level of care times 11.25% (MPR) 563 (PPB) 563 (PPB) minus 200 capacity of current organization 363 (TPPB) = unmet need of 363 (TPPB)

	• If the number of TPPB is greater than zero = unmet need. • If the number of TPPB is less than zero = no unmet need. The data used in the methodology described above will be pulled quarterly and posted on the MDHHS PACE website. MDHHS will also conduct an ongoing analysis to determine the effectiveness of the methodology. If an unmet need is determined, the current PACE organization will have the opportunity to submit expansion plans for review. If the current PACE organization fails to submit a plan for expansion, MDHHS will allow proposals from other organizations.

4.4.A. UNMET NEED PROCESS

A prospective PACE entity must submit a letter of intent to MDHHS that includes:

- Name of organization
- Location of the PACE center
- Service area by county and/or zip code (if applicable)

MDHHS will confirm whether there is an unmet need by utilizing existing methodology.

<u>If an unmet need is determined:</u>

- Upon determination of unmet need, MDHHS will send a letter within 14 business days to the prospective PACE entity to confirm the receipt of their letter of intent. The letter will confirm whether there is an unmet need and the next steps for right of refusal.
- MDHHS will send a letter to the current PACE provider within 14 business days that an unmet need was determined, and a prospective PACE entity has requested their current service area. The current PACE provider will be given the opportunity to submit a plan to expand capacity sufficient to accommodate need and will have six (6) months from the notice of determination of unmet need to submit an expansion plan.
- An expansion plan from a current PACE provider must include:
  - Letter of Intent
  - Location (if applicable)
  - Service Area
  - Capacity increase
  - Estimated timeline
- If the current PACE provider's expansion plan is approved by MDHHS, they will have 90 calendar days from approval to submit a feasibility study. Once the feasibility study is received, current policy timelines will be followed. Refer to the Initial Applications subsection of this chapter for additional information regarding expansion timelines.
  - The current PACE provider must provide quarterly updates to MDHHS to ensure that the organization is making progress on the plan they submitted to address the unmet need.

- If the current PACE provider chooses to not submit an expansion plan within six (6) months, MDHHS will move forward with requesting the prospective PACE entity's submission of a feasibility study within 90 calendar days of notice.

If an unmet need is not determined:

- MDHHS will send a letter within 14 business days of notice to the prospective PACE entity that an unmet need was not determined and, therefore, will not accept their letter of intent.

SECTION 5 – BECOMING A PACE ORGANIZATION

Information regarding the process to become a PACE organization is available on the MDHHS website. Any entity seeking to become a PACE organization in Michigan may contact MDHHS regarding state-specific requirements. (Refer to the Directory Appendix for contact and website information.)

RURAL HEALTH CLINICS

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SECTION 1 – GENERAL INFORMATION

1.1 RURAL HEALTH CLINIC CERTIFICATION

This chapter provides policy and reimbursement information specific to Rural Health Clinics (RHCs) and is to be used in combination with other chapters of the Medicaid Provider Manual.

In compliance with the Rural Health Clinic Services Act of 1977 (Public Law 95-210), the Medicaid program reimburses certified and enrolled RHCs for services provided to Medicaid beneficiaries in the State of Michigan. To become certified as a RHC in Michigan, clinics must make application for RHC status through the designated state-certifying agency. (Refer to the Directory Appendix for contact information.) Based on information in the application, the certifying agency determines if an applicant clinic meets the staffing and location requirements for certification. If a clinic appears eligible, an on-site visit is conducted. If a clinic meets all the requirements, the certifying agency makes a recommendation for certification to the Centers for Medicare & Medicaid Services (CMS). CMS makes the final determination as to a clinic's eligibility for RHC status and notifies the Michigan Department of Health and Human Services (MDHHS) when eligibility is granted.

RHCs may be provider-based or independently operated. Provider-based RHCs may be operated by a hospital, skilled nursing facility (SNF) or home health agency (HHA). An independent RHC is permitted to occupy a permanent structure or be located in a mobile unit. RHCs may be publicly or privately held clinics and they may be operated on a profit or not-for-profit basis.

1.2 GENERAL REIMBURSEMENT INFORMATION

Medicaid-enrolled RHCs are reimbursed with a prospective payment system (PPS) in compliance with Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. Specific information related to RHC reimbursement is contained in the Rate Setting Section of this chapter.

SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT

MDHHS requires all RHCs to have a Type 2 (Organization) National Provider Identification (NPI) number in order to receive the enhanced RHC reimbursement. For RHCs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the RHC fails to obtain and/or use the correct NPI number, the RHC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

All inquiries related to provider enrollment should be directed to the MDHHS Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

2.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICE

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the psychologist, social worker, professional counselor, or marriage and family therapist is reimbursed under the RHC PPS. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.

2.2 NONENROLLED PROVIDERS

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the RHC PPS. Since MDHHS does not directly

enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.

SECTION 3 – BENEFITS

RHC services subject to PPS reimbursement are RHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.

- Physician (MD, DO), podiatrist, chiropractor, and optometrist professional services, and services and supplies incidental to physician services, including certain drugs and biologicals that cannot be self-administered, immunizations and their administration.
- Licensed physician's assistant and advanced practice registered nurse (NP, CNS, CNM) services, and the services and supplies incidental to these services as would otherwise be furnished by, or incidental to, physician services.
- Clinical psychologist and clinical social worker services, and services and supplies incidental to these services as would otherwise be furnished by, or incidental to, physician services.
- Dental services, and services and supplies incidental to dental services.

Primary care services that are covered and reimbursed under the PPS are defined as the above listed services provided in a place of service that is the RHC's office or clinic, patient's home, skilled NF, domiciliary facility or NF.

3.1 SERVICES AND SUPPLIES INCIDENTAL TO AN RHC VISIT

RHC services and supplies incidental to an RHC visit are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral part of professional services furnished by a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, NP or CNS (under the terms of a collaborative agreement with a physician), CNM or licensed physician's assistant (under the terms of a practice agreement.
- Furnished under the direct personal supervision of a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, NP or CNS (under the terms of a collaborative agreement with a physician), CNM or licensed physician's assistant (under the terms of a practice agreement).
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a NP, CNS, CNM, or licensed physician's assistant only if such a person is permitted to supervise such services under the written policies governing the RHC.

3.2 SERVICES EXCLUDED FROM RHC REIMBURSEMENT

Payment for any other Medicaid covered services not defined as a primary care service are Medicaid-covered under fee-for-service (FFS) policies. Services not listed as primary care services are excluded from the RHC prospective payment rate (PPR).

3.3 Telemedicine

An RHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.4 Children's Health Insurance Program Services

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through RHCs when covered by the Children's Health Insurance Program (CHIP). Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act.

For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual reconciliation of these encounters provided by RHCs. (Refer to the Eligibility Groups Subject to PPS Methodology subsection of this chapter for additional information.)

For Healthy Kids–Expansion, MIChild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by RHCs. The RHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.

SECTION 4 – ENCOUNTERS

4.1 DEFINITION

Reimbursement to RHCs under the PPS requires that each office visit that meets the following definition of an encounter be counted for payment purposes.

An encounter is a face-to-face visit or an interaction using a qualifying telemedicine modality (audio/visual or audio-only) between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's medical record. Encounters may be classified as medical or behavioral health.

An RHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of two encounters are allowed per beneficiary per day (one medical and one behavioral health). In cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters.

- Example 1: A beneficiary sees a physician at the RHC to treat bronchitis and then sees an optometrist on the same day for an eye exam. These visits count as one encounter (medical).
- Example 2: A beneficiary sees a physician at the RHC, and then later sees a social worker on the same day. These visits may be classified as two encounters (one medical and one behavioral health).
- Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).

Encounters include provision of service by the following professionals:

- Licensed physicians (MD, DO), dentists, optometrists, podiatrists, chiropractors, CNPs (who have a collaborative agreement with a physician), CNMs, physician assistants, dental hygienists, or dental therapists.
- Clinical psychologists or clinical social workers.

The following examples help to define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by physicians, dentists, or other health providers that do constitute encounters.

- An RHC may be credited for more than one encounter by the same health professional on the same day. For example, a beneficiary suffers illness or injury requiring additional diagnosis or treatment on the same date of service, or a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg. These visits are classified as two encounters, and the patient's medical record must document the circumstances of the two encounters.
- An RHC may be credited for encounters by different health professionals on the same day. For example, if a patient first sees a physician at the RHC and then sees a clinical psychologist, these visits are classified as two encounters.
- An encounter may take place in the RHC or at another approved location.

The encounter criteria are **not** met in the following circumstances:

- Provider participation in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.
- Nursing services such as taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling or dispensing prescriptions.
- Calling in prescriptions, filling out insurance forms, etc.
- Allergy injection(s).

4.2 Eligibility Groups Subject to PPS Methodology

The following list identifies Medicaid eligibility groups that are subject to the PPS methodology:

Medicaid	RHC primary care services constitute encounters covered by Medicaid.
Qualified Medicare Beneficiaries	Medicaid is billed coinsurance and deductibles for Qualified Medicare Beneficiaries (QMBs), and the services covered by Medicare are included as encounters.
Medicaid Health Plan Enrollees	Medicaid-covered services provided by a RHC to Medicaid-eligible beneficiaries enrolled with a Medicaid Health Plan (MHP) are Medicaid encounters if the following conditions are met: ▪ The RHC and MHP must have a signed contract outlining payment provisions in order for the RHC to provide Medicaid-covered services to the MHP enrollee. ▪ The contract must provide for the MHP to reimburse the RHC at a fair market rate for similarly situated beneficiaries served by a non-RHC provider. The MHP must implement a level of payment equal to, or above, that of other subcontracting arrangements when entering into a subcontract with a RHC. ▪ The RHC must file information with the MDHHS HCRD in a format determined by MDHHS showing encounters and payments of Medicaid beneficiaries enrolled with MHP. ▪ RHCs may not bill Medicaid for MHP beneficiaries.

	▪ After verification of the fair market rate by the HCRD, the difference between the RHC prospective payment rate and MHP payments are reconciled by MDHHS annually. ▪ The contract between RHCs and MHP services is subject to review and verification by MDHHS.
Healthy Kids Dental	Dental services provided to Medicaid beneficiaries enrolled in the ***Healthy Kids Dental*** program are eligible for the PPR. RHCs should report Medicaid information on encounters and revenue in the annual reconciliation report. The RHC receives the difference between the PPR and the revenue received as part of the annual reconciliation.
Medicare/Medicaid	Medicaid covered primary care services provided to Medicare/Medicaid dual eligibles are considered Medicaid encounters and are reimbursed under the PPS methodology.

4.3 Eligibility Groups Not Subject to PPS Methodology

If an individual does not have Medicaid eligibility (i.e., is eligible for CSHCS-Title V), the services and costs are not Medicaid RHC services. CSHCS may be paid FFS rates only.

SECTION 5 – RATE SETTING

The RHC is reimbursed on a per visit basis for RHC services. In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000. MDHHS defines reasonable costs as the per-visit amount approved and paid by Medicare. For RHCs that have a fiscal year ending other than September 30, the PPR is prorated based on the number of months in each period covered by a different prospective rate.

The per visit amount is adjusted each year (beginning on October 1, 2001) by 100 percent of the Medicare Economic Index for the prior calendar year (i.e., the adjustment effective October 1, 2001 reflects the index for calendar year 2000).

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the RHC. An adjustment to the per-visit amount based upon a change in the scope of services becomes effective as determined by MDHHS.

Any rate setting/cost settlement related questions should be directed to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

5.1 ESTABLISHING RATES FOR NEW CLINICS

An entity that initially qualifies as an RHC after fiscal year 2000 will be paid as follows:

- Upon enrollment, an interim prospective payment rate (PPR) will be established for new RHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The RHC will be cost settled at the end of its first fiscal year of operation.
- After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria:
  - The first year will be inflated to the second fiscal year end using the appropriate Medicare Economic Index (MEI) factors.
  - For independent RHCs, the rebased PPR shall not exceed the Medicare limit.
  - For provider-based RHCs (associated with a hospital with fewer than 50 enrolled beds), the PPR shall not exceed the statewide average cost per visit. The limit will increase annually at a minimum of the MEI factor.
  - For provider-based RHCs (associated with a hospital with 50 or more beds), the PPR shall not exceed the Medicare limit.

5.2 ALTERNATE PAYMENT METHODOLOGY

In accordance with State Plan authority, MDHHS may enter into an alternative payment methodology with an RHC, referred to as a Memorandum of Understanding (MOU). Reimbursement for Medicaid primary care services provided by an RHC to Medicaid beneficiaries is subject to the terms of the signed MOU. For an RHC paid under the MOU, the PPS base methodology described within this chapter will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Social Security Act.

The MOU is effective when both MDHHS and an RHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The MOU does not supersede any corresponding policy in the MDHHS Medicaid Provider Manual but documents the clinic's acceptance of the terms outlined in the Michigan Medicaid State Plan. If an RHC does not sign the MOU, reimbursement and corresponding policy defaults to that which is described under the PPS methodology and outlined in this manual.

5.3 Quarterly Payments

RHCs receive a quarterly payment. This payment is an estimate of the difference between the payment the RHC receives from various sources (FFS, MHP, Medicare and other insurance) and the amount the RHC should receive under the PPS. These quarterly payments are included in the annual reconciliation. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to RHCs. The RHC may request a change in the quarterly payment through the MDHHS HCRD.

SECTION 6 – BILLING

6.1 BILLING RURAL HEALTH CLINIC SERVICES

RHC services must be billed according to instructions contained in the Billing & Reimbursement for Institutional Providers Chapter of this manual. RHCs must refer to that chapter for information needed to submit claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the RHC of its action. If the RHC performs a service that must be billed on the professional claim form, refer to the Billing & Reimbursement for Professionals Chapter of this manual. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the RHC to properly bill all Medicaid FFS claims. Incorrect or improper billing may adversely affect reimbursement since the annual reconciliation and final reimbursement is based on approved claims.

The Type 2 (Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number of the practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field:

- Physicians (includes dentists, podiatrists, optometrists, and chiropractors)
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Licensed Psychologists (Doctoral Level)
- Social Workers (Master's Level)
- Professional Counselors (Master's or Doctoral levels)
- Marriage and Family Therapists
- Limited Licensed Psychologists (Master's or Doctoral Level)

Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Type 2 (Organization) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

6.2 Place of Service Requirements

Place of service codes are not applicable to institutional billing. However, if the RHC performs a service that must be billed on the professional claim form within the clinic, RHCs must use place of service (POS) code 72. For services provided outside the RHC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

RHCs may provide Medicaid covered services in settings other than the RHC office, beneficiary's home, nursing facility or domiciliary facility, but these services are not included in the PPS reimbursement methodology. Services provided outside of the settings noted here are reimbursed at FFS rates.

6.2.A. Billing Requirements for Group Prenatal Care Services

Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) methodology at the Medicaid fee screen reimbursement rates for these services. RHCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) coded as identified in the Billing & Reimbursement for Professionals chapter of this manual.

6.3 Clinical Trials

The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information.

All RHC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. In addition, RHC claims must include:

- A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)
- Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim.
- Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1.
  - HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study.
  - HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.

6.3.A. Reporting Non-Covered Services

Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs,

providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.

6.4 Billing for Maternity Care

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of service (RHC and hospital). In order for the RHC to be reimbursed for prenatal visits under the PPS methodology, the RHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology.

If the RHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

6.5 Other Insurance

Billing instructions related to coordination of benefits are published in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the RHC must still bill the procedure code to receive credit for the encounter. (Refer to the Billing & Reimbursement Chapters of this manual for specific billing guidelines.)

6.6 Medicare and Medicaid Crossover Claims

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate FFS procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

6.7 Copayments

Medicaid copayments for chiropractic, dental, physician, podiatry, and vision services are waived under the RHC benefit as part of the reconciliation. (Services requiring copayments are listed in the General Information for Providers Chapter of this manual.)

6.8 Dental Claims

RHCs providing dental services must refer to the Dental and to the Billing & Reimbursement for Dental Providers Chapters of this manual for information regarding program coverages, prior authorization requirements, claims completion and billing instructions.

SECTION 7 – RISK CONTRACTS

RHCs may enter into risk contracts with MHPs for nonprimary care services. However, these contracts are not included in the reconciliation process. All RHC reconciliations are for primary care services only.

7.1 SCOPE OF SERVICE

The prospective payment rate may be adjusted for an increase or decrease in scope of service. Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default). For example, an independent RHC that changes ownership to a provider-based RHC when the hospital has less than 50 beds is considered to have a change of scope.

7.1.A. INCREASE IN SCOPE OF SERVICE

An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved RHC benefits that no current professional staff is licensed to perform.

7.1.B. DECREASE IN SCOPE OF SERVICE

A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

7.1.C. CHANGES THAT DO NOT CHANGE THE SCOPE OF SERVICE

An increase or decrease in scope of service does not result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- an increase, decrease or change in number of staff working at the clinic.
- an increase, decrease or change in office hours.
- an increase, decrease or change in office space or location.
- the addition of a new site that provides the same set of services.
- an increase, decrease or change in equipment or supplies.
- an increase, decrease or change in the number or type of patients served.

7.2 Notice of Intent to Change Scope of Service

If a RHC intends to change its scope of service, the MDHHS HCRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. Notification should include the following documentation:

- Complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of encounters.
- Estimates of the cost change on the current Medicaid encounter rate.
- The proposed customary charges for this service by the RHC.
- The customary charges for this service by other providers in the area served by this RHC.
- The amount to be paid by an MHP for this service for various programs (Medicare/Medicaid).
- The current Medicare encounter rate.
- Medicare fee screen for this service for non-full cost providers.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.), and type (MHP, fee screen/contracted amount).
- Estimated change in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from the state-licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, encounters or approvals/denials of the change.
- Other information as requested by the HCRD.

After a review of the information submitted, the HCRD notifies the RHC of its determination regarding a rate change, including the effective date of any change.

SECTION 8 – RECONCILIATION REPORTING

Medicaid Reconciliation Reports must be completed by each RHC in order to receive reimbursement under the PPS.

The RHC must file the following documents at the end of its fiscal year for PPS reimbursement:

- A copy of its filed Medicare Cost Report and Trial Balance
- A completed copy of the Medicaid Reconciliation Report

Encounter data for RHC services provided to beneficiaries through Medicaid Health Plans, ***Healthy Kids Dental***, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS).

No individual payment information is needed if payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided.

Upon review and audit, MDHHS will reimburse the difference between the RHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the regional Prepaid Inpatient Health Plan (PIHP).

8.1 REPORT FILING

RHCs must file Reconciliation Reports and supplemental documents to the MDHHS HCRD annually. Due dates are consistent with the Medicare Cost Report filing requirement. If the required reconciliation report and supplemental documents are not submitted within the required time limit, the RHC waives its right to the PPS reimbursement for that year.

The reconciliation report is the basis for determining future quarterly payments and the current year's reconciliation. The report must be an original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports and should be for the same fiscal period and cover the same sites as the Medicare Cost Report. Improperly completed or incomplete filings are returned to the facility for proper completion and must be resubmitted to MDHHS within 30 days of date of receipt.

8.2 ACCOUNTING AND RECORD KEEPING

RHCs must maintain, for a period of not less than seven years from the end of the fiscal year of the Reconciliation Report, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the information reported. If there are unresolved issues at the end of this seven-year period, the records must be maintained until these issues are resolved.

The MDHHS HCRD retains each required Reconciliation Report and supplemental documents submitted by the RHC for seven years after issuance of a final decision. In the event there are unresolved issues at the end of this seven-year period, the report is maintained until such issues are resolved.

SECTION 9 – AUDIT, SETTLEMENTS AND APPEALS

An annual reconciliation is performed to assure that the prospective payment rate is paid to the RHC for all eligible encounters. The reconciliation process begins with the receipt of the Reconciliation Report and supplemental documents and ends with the issuance of the Notice of Amount of Program Reimbursement.

9.1 DESK REVIEWS AND FIELD AUDITS

The desk review may include procedures that:

- Verify the completeness and mathematical accuracy of all schedules in the report.
- Compare the Reconciliation Report with MDHHS paid claim and encounter data.
- Identify the need for supporting documentation and arrange to receive same.
- Identify the need for a field audit examination necessary to conclude final reconciliation calculations.
- Compare reported data with industry norms as an aid to the audit scope determination.

Field audits may be conducted to verify information on the Reconciliation Report.

9.2 MEDICARE AUDIT

The Medicare intermediary may perform audits of the RHC. These audit results may be used to verify information or for statistical purposes.

9.3 INITIAL RECONCILIATION AND SETTLEMENT

An initial reconciliation is calculated after the annual reconciliation report is received. The initial reconciliation is processed approximately four months after the reconciliation report is received, with the payment or recovery made at that time. Future quarterly payments are adjusted based on the information in the initial reconciliation.

9.3.A. UNDERPAYMENTS TO AN RHC

Based on the annual reconciliation, MDHHS reimburses any underpayment due an RHC through a gross adjustment. This gross adjustment is shown in a Remittance Advice (RA). MDHHS retains the right to withhold a portion of any initial payment based on individual circumstances.

9.3.B. OVERPAYMENTS TO AN RHC

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and will be recovered by MDHHS. The recovery starts approximately 30 days after notification to the RHC. The gross adjustment stops all payments to the RHC's physician(s) until the full amount is recovered.

9.4 Audit Adjustment Report

The Audit Adjustment Report contains a list of all Program data adjustments made to the Medicaid Reconciliation Report by MDHHS audit staff.

9.4.A. Audit Adjustment Report

The Audit Adjustment Report must be accepted or rejected by the RHC within 30 calendar days of its mailing date.

If the RHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the RHC should sign the report and mail it to MDHHS HCRD. (Refer to the Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement is then mailed to the RHC. No further administrative appeal rights are available for the adjustments contained in the Audit Adjustment Report.

If the RHC has not responded within this time period, MDHHS shall issue a Notice of Amount of Program Reimbursement that is the final determination of an adverse action. No further administrative appeal rights are available.

9.4.B. Notice of Amount of Program Reimbursement

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

9.4.C. RHC Rejection of the Audit Adjustment Report

Within 30 calendar days of the mailing date of the Audit Adjustment Report, the RHC may reject any or all of the findings in the Audit Adjustment Report and request a post-audit conference.

The Post-Audit Conference is an informal process where the MDHHS HCRD staff and the RHC may resolve differences prior to an appeal and/or formal hearing. The process is initiated by the RHC after the receipt of the Audit Adjustment Report. The RHC must request in writing a Post-Audit Conference with the HCRD and indicate in that letter the area(s) of disagreement. The letter must state the appropriate regulation and/or other appropriate decisions that support the RHC's position and be sent to MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

The RHC or its representative must present, either before or at the time of the Post-Audit Conference, the audit staff with the documents and arguments that support its position relative to the disputed issue(s). The audit staff will explain to the RHC the basis for its findings. This step does not stop the recovery of monies due Medicaid.

9.5 APPEALS

RHCs have the right to appeal any adverse action taken by MDHHS, unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). The appeal must be submitted in writing and mailed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

The appeal process is outlined in the MDHHS Medicaid Provider Reviews and Hearings administrative rules, Michigan Administrative Code R400.3402 through R400.3425. Any questions regarding the appeal process should be directed to MOAHR.

RHCs may appeal their respective Notice of Program Reimbursement if the contested issue(s) is other than those precluded due to failure to appeal rate adjustment(s) in the Audit Adjustment Report according to established time frames. Appeals accepted as appropriate are also governed by the aforementioned MDHHS Medicaid Provider Reviews and Hearings rules.

SCHOOL SERVICES PROGRAM

This chapter is comprised of three parts:

The **SCHOOL SERVICES PROGRAM** portion of the chapter outlines the general requirements and direct services for the program.

The **SCHOOL SERVICES PROGRAM ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT** portion of the chapter outlines the program's administrative outreach requirements.

The **SCHOOL SERVICES PROGRAM RANDOM MOMENT TIME STUDY** portion of the chapter focuses on the RMTS requirements for the program.

SCHOOL SERVICES PROGRAM

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts (ISDs) and their associated local education agencies (LEAs), Detroit Public Schools Community District (DPSCD), and Michigan School for the Deaf (MSD).

This chapter describes the coverage and reimbursement policy for direct medical services, targeted case management (TCM), and personal care services (PCS). Coverage applies to individuals up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP), Non-Public Service Plan (NPSP), other individualized health care plan, or as otherwise medically necessary. The Centers for Medicare & Medicaid Services (CMS) has determined that services provided in the "school" setting include services provided by qualified school staff in the "home" setting when necessary. For the purpose of this document, IEPs, IFSPs, NPSPs, individualized plans of care, and all other plans of care will be referred to as "plan of care (POC)" for simplicity.

These services assist students, with or without a disability, in benefiting from educational and related services. Medicaid reimbursement, through the Michigan Department of Health and Human Services (MDHHS), addresses the medical service needs of beneficiaries receiving educational and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover "related services" which are specified in Federal Medicaid statute as medically necessary and "included in the student's IEP/IFSP/NPSP established pursuant to Part B of the IDEA or furnished to a disabled infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act." On December 15, 2014, CMS issued State Medicaid Director Letter (SMDL) 14-006 *Medicaid Payment for Services without Charge (Free Care)*. Based on that guidance, ISD/LEAs can seek reimbursement for all covered services provided to all students enrolled in Medicaid, regardless of whether the services are provided at no cost to other students, and allows for Medicaid reimbursement for services delivered outside of an IEP, IFSP, or NPSP.

Section 504 of the Rehabilitation Act of 1973 requires school districts to provide or pay for certain services to make education accessible to all students. These services are described in an individualized POC and are provided free of charge to eligible students. Medicaid reimbursement is allowed for these services.

Medicaid services provided through the School Services Program (SSP) are not covered for students involuntarily residing in a detention setting with a Benefit Plan ID of INCAR-ESO, INCAR-MA, INCAR-MA-E, or MA-HMP-INC.

Coverage is based on medical necessity and allows Medicaid-covered services being provided in the school setting to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid-covered services. Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to ISDs and their associated LEAs, DPSCD, and MSD. For the purpose of this document, the ISDs and their associated LEAs, DPSCD, and MSD will be referred to as "ISDs" for simplicity.

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. Medicaid services provided by the ISDs/LEAs are to be provided as outlined in the POC and are not expected to replace or substitute for services already provided by other agencies. If services are being provided by another program, ISDs/LEAs are expected to coordinate the services to prevent service overlap and to ensure continuity of care to the Medicaid beneficiary. All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis. Enrollment as a SSP provider is not expected to result in any change in the ISD/LEA's set of existing services or service utilization. MDHHS periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.

Covered services do not require prior authorization but must be documented and provided by qualified staff members as specified in the Covered Services section of this chapter.

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability.
Assistive Technology Service	The term "assistive technology service" means any service that directly assists a student with a disability in the selection, acquisition or use of an ATD.
Caring for Students (C4S)	Program component enabling reimbursement of Medicaid costs associated with providing services to students outside of an IEP/IFSP/NPSP.
Certified Public Expenditure	A certified public expenditure is an expenditure of funds by a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match.
Direct Medical Services	Direct medical services, specialized transportation, TCM, and PCS provided in the school setting and reimbursed by Medicaid.
Direct Service Claiming (DSC)	Program component enabling reimbursement of Medicaid costs associated with providing services to students within an IEP/IFSP/NPSP. This component was previously known as School-Based Services (SBS).

Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS)	▪ Durable Medical Equipment (DME) items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when: ➢ It is medically and functionally necessary to meet the needs of the beneficiary. ➢ It may prevent frequent hospitalization or institutionalization. ➢ It is life sustaining. ▪ Medical supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that: ➢ Treat a medical condition. ➢ Prevent unnecessary hospitalization or institutionalization. ➢ Support DME used by the beneficiary. ▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Enable a beneficiary to ambulate or transfer. ▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Prevent or reduce contractures. ➢ Facilitate healing or prevent further injury.
Enrolled Medicaid Provider	The 56 Michigan ISDs, DPSCD, and MSD who have enrolled and revalidated with the MDHHS Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment subsystem.
HA Modifier (C4S)	The HA modifier is used with the appropriate procedure codes to identify services delivered outside of an IEP/IFSP/NPSP.
HT Modifier (multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA assessment. Each qualified staff bills using the appropriate procedure code followed by the HT modifier (multi-disciplinary team).
IDEA (Individuals with Disabilities Education Act)	The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.
IDEA Assessment	An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of IDEA of 1990 as amended in 2004 and are related to the evaluation and functioning of the individual.

IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of 2.5 and 26 years in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for Medicaid eligible students up to the age of 21.
IFSP (Individualized Family Service Plan)	A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.
ISD (Intermediate School District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 56 intermediate school districts.
ISD/LEA Clinician	Any clinician/provider employed or contracted through an ISD or associated LEA.
MDE (Michigan Department of Education)	A department within the State of Michigan.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the student's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the POC. Medical necessity may support educational outcomes and goals.
MiLEAP (Michigan Lifelong Education, Advancement, and Potential)	A department within the State of Michigan government that prioritizes education from pre-school through post-secondary with a focus on preparing children for kindergarten and helping more people earn a skill certificate or degree to help them obtain good paying jobs.
NPSP (Non-Public Service Plan)	A written plan for services for eligible students between the ages of 2.5 and 26 years in non-public schools within Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's NPSP for Medicaid eligible students up to the age of 21.
Plan of Care (POC)	A POC is a form that summarizes a student's health conditions, specific care needs, and current treatments. The POC outlines what needs to be done to manage the student's care needs and organizes and prioritizes services. The student's IEP/IFSP/NPSP form, individual treatment plan, behavioral health plan, or other plan may suffice as the POC as long as the document contains the required components described under the Plan of Care subsection of this section.
Random Moment Time Study	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.

School Services Program (SSP)	A program which provides medically necessary Medicaid-covered services in the school setting. All Michigan ISDs and their associated LEAs, DPSCD, and MSD participate in the School Services Program.
Specialized Transportation	Transport to and from the student's pick-up and drop-off site when school-based services are provided for students through an IEP/IFSP/NPSP. Reimbursement for Specialized Transportation is not available for students receiving services outside of an IEP/IFSP/NPSP.
TL Modifier (Re-evaluation of Existing Data [REED])	The TL modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the student's eligibility for special education services.
TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary evaluation team assessment for the development, review and revision of an IEP/IFSP/NPSP POC. Each qualified staff bills for this assessment using the appropriate procedure codes with the modifier.
52 Modifier	The 52 modifier is used with the appropriate procedure codes to describe circumstances in which services provided were reduced in comparison to the full description of the service.
59 Modifier	The 59 modifier is used with the appropriate procedure codes to identify when a service was distinct or independent from other services provided on the same day with the same Current Procedural Terminology (CPT) codes.
93 Modifier	The 93 modifier is used with the appropriate procedure codes to identify when service is provided via telemedicine using audio only.
95 Modifier	The 95 modifier is used with the appropriate procedure codes to identify when a service is provided via telemedicine using audio and video.

1.1 Children's Special Health Care Services

The Medicaid SSP covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SSP providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only) and must not submit claims for these beneficiaries.

1.2 Third Party Liability

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid for services provided outside of an IEP/IFSP/NPSP. If a Medicaid-eligible student is presently covered by another resource and the ISD/LEA does not bill the other resource, Medicaid cannot be billed for the services outside of an IEP/IFSP/NPSP. ISDs/LEAs are not required to bill other resources prior to billing Medicaid for services provided through an IEP/IFSP/NPSP. (Refer to the Coordination of Benefits chapter for additional information.)

1.3 Medical Necessity

A Medicaid service provided by an ISD/LEA is determined medically necessary when all of the following criteria are met:

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self-care;
- Is included in the student's IEP/IFSP/NPSP, other plan of care, or is otherwise medically necessary; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of their practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. Electronic and faxed signatures are acceptable; however, stamped signatures are not acceptable. Behavioral health services do not require written orders.

1.4 Under the Direction of and Under the Supervision of

Certain specified services may be provided under the direction of or under the supervision of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the student's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, ensuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.

"Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner to learn from the supervisor's experience and expertise, as well as to ensure good service to the student.

1.5 Covered Services

Medicaid covered services billed by ISDs/LEAs include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services
- Assistive Technology Device Services
- Physical Therapy Services
- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services

- Physician and Psychiatrist Services
- Personal Care Services (PCS)
- Targeted Case Management (TCM) Services (DSC services only)
- Specialized Transportation Services (DSC services only)

1.6 Service Expectations

The POC must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures, and schedules for determining whether the objectives are being achieved within an appropriate period of time (at least annually). All therapy services must be skilled (i.e., require the skills, knowledge, and education of a licensed or properly credentialed provider). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, or speech, language and hearing therapy by this program.

To be covered by Medicaid, behavioral and physical health services must address a beneficiary's medical need that affects their ability to learn in the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals.

Group therapy or treatment must be provided in groups of two to eight, with the specific number of students in the group identified in all documentation. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one beneficiary who is part of the class currently in session, the service is not reimbursable.

Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music, and recreation therapies are not covered services.

Medicaid is required to follow the procedure code definition from the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals. Procedure codes referencing office or outpatient facility include the medical services provided in the school setting. Procedure codes that do not specify a unit of time are to be billed per session. Group therapy is billed per beneficiary.

Certain CPT/HCPCS code descriptions include a specified unit of service time. Service times are based on the time it generally takes to provide the service. If the CPT/HCPCS code specifies "up to 15 minutes of service", the service may be billed in a unit of time from 1-15 minutes. If the CPT/HCPCS code specifies a unit of time "each 15 minutes", the CPT/HCPCS code may be billed when the service time equals more than half of the specified unit of time. Any additional time cannot be billed unless the full time specified is reached for the prior unit.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

1.7 Plan of Care (POC)

Requirements	If an evaluation indicates that Medicaid-covered services are required, qualified staff must develop and maintain a POC for the student. The student's IEP/IFSP/NPSP or individual POC form may suffice as the POC if the IEP/IFSP/NPSP or individualized POC contains the required components described below. Only qualified staff may initiate, develop, or change the student's POC. The POC must be signed, titled, and dated by a qualified medical provider prior to billing Medicaid for services and must be retained in the student's school clinical record. By signing the POC, the qualified medical provider is indicating that they have reviewed the POC and it is appropriate for the student's needs. The qualified medical provider is not taking individual responsibility for the provision or supervision of services, coordination of services, or taking personal liability for the services performed. Services may be billed in the absence of a POC for up to 30 calendar days when determined to be medically necessary. (Refer to the Covered Services section of this chapter for definitions of qualified staff.)
Components	The POC, which is an immediate result of the evaluation, must consist of the following components: ▪ Student's name and date of birth; ▪ Description of the student's qualifying diagnosis or medical condition; ▪ Time-related goals that are measurable and significant to the student's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators of when the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals, as applicable; ▪ Plan for reaching the functional goals and outcomes in the POC; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ Signature, title, and date of the qualified medical provider signing the POC.

Individuals Authorized to Review/Sign the POC	The POC must be signed by a qualified medical provider listed below: ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully-licensed speech-language pathologist (SLP) ▪ A licensed audiologist ▪ A fully-licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A certified school psychologist ▪ A licensed marriage and family therapist ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A licensed physician assistant (PA) ▪ A licensed nurse practitioner (NP) ▪ A licensed clinical nurse specialist (CNS) ▪ A registered nurse (RN) ▪ A qualified school nurse
Review	The POC must be reviewed and updated at least annually, or more frequently if the student's condition changes or alternative treatments are recommended.
Revision	If the POC is updated in a way that changes the student's diagnosis and medical condition, goals, plan for reaching the functional goals and outcome, or frequency or duration of services, the POC must be revised and a new signature from a qualified medical provider is required.

1.8 Prescriptions, Referrals, and Authorizations

Prescriptions, referrals, and authorizations must include:

- Student's name
- Type of services to be provided
- Provider's typed or printed name
- Provider's National Provider Identification (NPI) number when appropriate

- Signature, including date of the signature, by a qualified medical provider acting within their scope of practice, as outlined in the Practitioner Signatures subsection

1.9 Evaluations

Evaluations for medical services are covered under any of the following conditions:

- Performed as part of the IDEA assessment.
- Performed as part of the student's initial assessment.
- The student left and is re-entering the SSP.
- An initial development, review or revision of the student's POC will occur.
- A change or decrease in function occurs.

1.9.A. Evaluations Performed for DMEPOS Medical Suppliers

If an ISD/LEA physical therapist, occupational therapist, speech-language pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.

1.10 Practitioner Signatures

In all documentation requiring a signature, the signature must be handwritten by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. An electronic signature must specifically identify and authenticate the individual practitioner. This applies to all signatures within the program.

SECTION 2 – COVERED SERVICES

2.1 ASSESSMENT AND POC DEVELOPMENT, REVIEW AND REVISION

Definition	The assessment process includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of Early and Periodic Screening, Diagnosis and Treatment (EPSDT), and are related to the evaluation and functioning of the beneficiary. These services are reimbursable even if they do not result in the implementation of a POC. If a POC is developed and not implemented within one year of the date of assessment, then none of the services within that POC are covered and a new POC is required.
Provider Qualifications	Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA assessment. To be covered by Medicaid, staff must have the following Michigan current credentials: ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully-licensed speech-language pathologist (SLP) ▪ A limited-licensed speech-language pathologist (under the direction of a licensed speech-language pathologist) ▪ A licensed audiologist ▪ A fully-licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A certified school psychologist ▪ A board-certified behavior analyst (BCBA) ▪ A board-certified assistant behavior analyst (BCaBA) under the supervision of a BCBA ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed marriage and family therapist ▪ A licensed physician or psychiatrist (MD or DO) ▪ A licensed physician assistant (PA) ▪ A licensed nurse practitioner (NP) ▪ A licensed clinical nurse specialist (CNS) ▪ A registered nurse (RN) ▪ A licensed practical nurse (LPN)

	▪ A qualified school nurse
Procedure Codes	Qualified staff can bill for multiple types of assessments/evaluations/tests. All activities, such as meetings and written reports related to the assessment/ evaluation/test, are an integral part or extension of the service and are not separately claimable. For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) ▪ The **HA modifier** is used with the procedure code when billing for services provided outside of an IEP/IFSP/NPSP (C4S). This modifier is also used when an IDEA assessment does not result in the development of an IEP. ▪ The **HT modifier** is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA assessment. Each qualified staff bills using the appropriate procedure code followed by the HT modifier (multi-disciplinary evaluation team). The date of service is the date of determination of eligibility for special education or Early On® services. The determination date must be included in the assessment/evaluation/test. ▪ The **TL modifier** is used with the appropriate procedure codes to identify when a REED was used in the determination of the student's eligibility for special education services. ▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP POC. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. No modifier is used for assessments/evaluations/tests unless one of the following is true: ▪ The assessment/evaluation/test is to determine initial eligibility for Special Education. ▪ The assessment/evaluation/test is to determine eligibility for Special Education for an out-of-state transfer student. ▪ The assessment/evaluation/test is to determine ongoing eligibility for Special Education. ▪ The assessment/evaluation/test is to determine a change in eligibility for Special Education. ▪ The assessment/evaluation/test is to determine appropriate programs or services in Special Education. ▪ The assessment/evaluation/test is to transfer a student from Early On® to Part B. ▪ The assessment/evaluation/test is used to determine that the student is not eligible for Special Education, in which case the HT modifier is used. Each qualified staff bills for these activities using the appropriate procedure code with or without a modifier. The date of service is the date the assessment/evaluation/test is completed.

2.2 Occupational Therapy (Includes Orientation and Mobility Services and Assistive Technology Device Services)

2.2.A. Occupational Therapy Services

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	**Occupational Therapy:** Occupational therapy (OT) must be habilitative or rehabilitative, active or restorative, and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. OT services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or certified orientation and mobility specialist.
Prescription	Occupational therapy services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated no less than annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	OT services may be reimbursed when provided by: ▪ A licensed occupational therapist (OT); ▪ A licensed occupational therapy assistant (OTA) under the direction of a licensed OT; or ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP). NOTE: The OTA's services must follow the evaluation and POC developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the student's progress. All documentation must be reviewed and signed by the supervising OT.

Evaluations for Occupational Therapy	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by a licensed OT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student.
Assessments for Durable Medical Equipment	If an ISD/LEA occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.

Services	OT services include: ▪ Group therapy provided in a group of two to eight students; ▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; ▪ Wheelchair management/propulsion training; ▪ Independent living skills training; ▪ Coordinating and using other therapies, interventions, or services with the ATD; ▪ Training or technical assistance for the student or, if appropriate, the student's parent/guardian; ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the student receiving ATD services; ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; ▪ Evaluating the needs of the student, including a functional evaluation of the student. ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD; and ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.B. Orientation and Mobility Services

Definition	**Orientation and Mobility Services:** Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low-vision aids/devices, as appropriate.
Prescription	Orientation and mobility services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.

Provider Qualifications	Orientation and mobility services may be reimbursed when provided by: ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or ▪ A licensed occupational therapist.
Evaluations	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by an Orientation and Mobility Specialist (O&M) or a licensed occupational therapist. An evaluation for orientation and mobility services includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student.
Services	Orientation and mobility services include: ▪ Providing assistance in the development of skills and knowledge that enable the student to travel independently to the highest degree possible, based on assessed needs and the POC; ▪ Training the student to travel with proficiency, safety and confidence in familiar and unfamiliar environments; ▪ Preparing and using equipment and material, such as tactile maps, models, distance low-vision aids/devices, and long canes, for the development of orientation and mobility skills; ▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision; ▪ Communication skills training (teaching Braille is not a covered benefit); ▪ Systematic orientation training to allow safe movement within the student's environments in school, home and community; ▪ Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation;

	▪ Visual training to understand and use the remaining vision for those with low vision; ▪ Training necessary to activate visual motor abilities; ▪ Training to use distance low-vision aids/devices; and ▪ Independent living skills training.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.C. ATD Services

Definition	Assistive Technology Device (ATD) Services General Description: Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ A licensed OT; or ▪ A licensed OTA; or ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).
Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by a licensed OT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the student's ability to function;

	▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student in the school environment and home.
Assessments for DME	If an ISD/LEA OT performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs etc., is not a covered benefit of SSP; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the student or, if appropriate, the student's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the student receiving ATD services. ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the student, including a functional evaluation of the student. ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medicaid medical supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by SSP providers.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3 Physical Therapy Services (Includes ATD Services)

2.3.A. Physical Therapy Services

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Physical therapy (PT) may be habilitative or rehabilitative, active or restorative, and designed to correct or compensate for a medical problem. PT services require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	PT services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	PT services may be reimbursed when provided by: ▪ A licensed physical therapist (PT); or ▪ A licensed physical therapy assistant (PTA) under the direction of a licensed PT (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the student's progress). All documentation must be reviewed and signed by the supervising PT.
Evaluations for Physical Therapies	Evaluations are formalized testing and reports to determine a student's need for services and recommend a course of treatment. They may be completed by a PT. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (i.e., functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (e.g., strength, dexterity, range of motion) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student.

Assessments for DME	If an ISD/LEA physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.
Services	PT services include, but are not limited to: ▪ Group therapy provided in a group of two to eight students; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.B. ATD Services

Definition	**ATD Services General Description:** Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ a licensed physical therapist (PT); or ▪ a licensed physical therapy assistant (PTA).

Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by a PT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student in the school environment and home.
Assessments for DME	If an ISD/LEA physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.

Services	ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of SSP; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the student or, if appropriate, the student's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the student receiving ATD services. ▪ Evaluating the needs of the student, including a functional evaluation of the student. ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by SSP providers.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4 Speech, Language and Hearing Therapy (Includes ATD Services)

2.4.A. Speech, Language and Hearing Therapy

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to students with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the student. Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist, limited-licensed speech-language pathologist, or audiologist to provide the therapy.
Prescription	Speech, language, and hearing services require a referral by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All referrals must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.

Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A fully licensed speech-language pathologist (SLP); ▪ A licensed audiologist; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or ▪ A limited licensed SLP, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
Evaluations for Speech Pathology Services	Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by a licensed SLP or audiologist. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student. Evaluations may also include, but are not limited to: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the student's voice mechanism and the medical diagnosis.

Speech Assessments for DME	If an ISD/LEA SLP or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.
Services	Speech, language and hearing services include, but are not limited to: ▪ Group therapy provided in a group of two to eight students ▪ Articulation, language, and rhythm ▪ Swallowing dysfunction and/or oral function for feeding ▪ Voice therapy ▪ Speech, language or hearing therapy ▪ Speech reading/aural rehabilitation ▪ Esophageal speech training therapy ▪ Speech defect corrective therapy ▪ Fitting and testing of hearing aids or other communication devices
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4.B. ATD SERVICES

Definition	**ATD Services General Description:** Utilizing the description in Section 602(2) of IDEA, the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a student with a disability. That same description applies to students receiving services outside of an IEP/IFSP. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	ATD services must be prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and updated annually. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	ATD services may be reimbursed when provided by: ▪ A licensed audiologist ▪ A fully licensed speech-language pathologist (SLP)

Evaluations for ATDs	Evaluations are formalized testing and reports for the development of the student's POC. They may be completed by an audiologist or SLP. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the student in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The student's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the student's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the student's ability to function; ▪ Assessment of the student's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to ATD services, including a functional evaluation of the student in the school environment and home.
Assessments for DME	If an ISD/LEA audiologist or SLP performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. The clinician must perform and write their own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the student is also receiving physical therapy, occupational therapy, or speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD/LEA clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SSP program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit. ATD services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the student or, if appropriate, the student's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the student receiving ATD services. ▪ Evaluating the needs of the student, including a functional evaluation of the student. ATD services are intended to directly assist a student with a disability in the selection, coordination of acquisition, or use of an ATD.

	▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.5 Psychological, Counseling and Social Work Services

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definitions	Psychological, counseling, and social work services include planning, managing and providing a program of face-to-face services for students with diagnosed psychological conditions. Psychological, counseling, and social work services must require the skills, knowledge and education of a psychologist, counselor, social worker, or other qualified behavior health professional to provide treatment. Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy. Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a student who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.

Provider Qualifications	Psychological, counseling and social work services may be reimbursed when provided by: ▪ A licensed physician or psychiatrist ▪ A fully-licensed psychologist ▪ A limited-licensed psychologist under the supervision of a licensed psychologist ▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist ▪ A certified school psychologist ▪ A board-certified behavior analyst (BCBA) ▪ A board-certified assistant behavior analyst (BCaBA) under the supervision of a BCBA ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker ▪ A licensed marriage and family therapist
Evaluations	Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a student's behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed master's social worker must complete them.
Psychological Testing	Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a student's behavior and conditions relating to functioning. A fully-licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the student's condition. Medicaid does not cover the time that a student spends alone in testing. The student's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing. The psychological testing report must include all of the following: ▪ Student name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.

Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)
Crisis Intervention	Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the student's POC.

2.6 Developmental Testing

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language, and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the student's history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid.
Documentation	The developmental testing report must include all of the following: ▪ Student name and birth date; ▪ Tests administered; ▪ Treatment recommendations; and ▪ The dated signature of the person administering the tests.
Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: ▪ A fully-licensed psychologist ▪ A limited-licensed psychologist under the supervision of a licensed psychologist ▪ A licensed master's social worker ▪ A limited-licensed master's social worker under the supervision of a licensed master's social worker ▪ A licensed physician or psychiatrist
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.7 Nursing Services

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Nursing services are professional services relevant to the medical needs of the student provided through direct intervention. Direct service interventions must be medically-based services that are within the scope of the professional practice of the Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), School Nurse, Registered Nurse (RN), and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices. Services include, but are not limited to: ▪ Care coordination ▪ Catheterizations or catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. LPN services can only be billed if performed under the supervision of an RN or physician.
Prescription	Direct service interventions require a physician's, physician assistant, nurse practitioner's, or clinical nurse specialist's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the student's attending physician. The nurse is responsible for notifying the attending physician of any change in the student's condition which may result in a change or modification to the POC. All prescriptions must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Provider Qualifications	Nursing services may be reimbursed when provided by: ▪ A licensed Nurse Practitioner (NP); ▪ A licensed Clinical Nurse Specialist (CNS); ▪ A certified School Nurse; ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ A Licensed Practical Nurse (LPN) in Michigan.
Evaluations	A NP, CNS, RN, or School Nurse must complete the evaluations/assessments and prepare a nursing POC. An evaluation/assessment may be performed when a change in the student's medical condition occurs. LPNs cannot bill for evaluations/ assessments.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.8 Physician and Psychiatrist Services

NOTE: Telemedicine Services are covered in the Telemedicine Chapter of this manual.

Definition	Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a student's medical or other health-related condition. Physician/psychiatrist services include: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SSP may be billed and reimbursed through the enrolled ISD. Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled ISD.
Provider Qualifications	A licensed physician or psychiatrist (MD or DO) in Michigan.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) Procedure codes that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable.

2.9 Personal Care Services

Definition	Personal Care Services (PCS) are a range of human assistance services provided to students with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the student performs the task by themself. PCS may be provided when: ▪ The service is medically necessary. PCS is not covered if they are: ▪ Provided by a family member. A family member is described by CMS to be "legally responsible relatives"; thus, spouses of students and parents or guardians of minor students (including step-parents who are legally responsible for minor students). ▪ Not documented in the POC. ▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation. ▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. PCS may include, but is not limited to, assisting with the following: ▪ Eating/feeding ▪ Respiratory assistance ▪ Toileting ▪ Grooming ▪ Dressing ▪ Transferring ▪ Ambulation ▪ Personal hygiene ▪ Mobility/Positioning ▪ Meal preparation ▪ Skin care ▪ Bathing ▪ Maintaining continence ▪ Assistance with self-administered medications ▪ Re-direction and intervention for behavior ▪ Health-related functions through hands-on assistance, supervision, and cueing

Personal Care Paraprofessional Provider Qualifications	Personal care paraprofessional personnel are employed by the ISD/LEA and shall be qualified under the requirements established by their respective POC. Providers must be trained in the skills needed to perform covered services and must be under the direction of a qualified professional as designated in the POC. Paraprofessional personnel may include, but are not limited to: ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ Trainable Aides ▪ Behavioral Health Aides
Prescription	In accordance with 42 CFR 440.167, authorization for PCS may be done by a physician or "other licensed practitioner" operating within the scope of their practice. The State definition of "other licensed practitioner" consists of Registered Nurse (RN), Licensed Occupational Therapist (OT), Licensed Physical Therapist (PT), Licensed Master's of Social Work (MSW), or fully-licensed Speech-Language Pathologist (SLP). It is expected that PCS will be authorized by the appropriate practitioner and updated annually. All authorizations must conform to the standards outlined in the Prescriptions, Referrals, and Authorizations subsection of this chapter.
Documentation	PCS must be medically necessary and the need for the service must be documented in the student's POC. Each student's school clinical record must contain a completed, signed and dated monthly activity log. Any days where the student is absent must be documented on the monthly activity log. Days where the student was present and services were not provided must also be documented on the monthly activity log. The monthly activity log may be in an electronic format; however, all services provided to the student must be listed. Service categories (i.e., toileting, feeding, transferring, etc.), times, and frequencies must be documented either in the POC, in an attached document, or in the student's treatment authorization.
Procedure Codes	For a complete listing of procedure codes, refer to the CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.10 Targeted Case Management (TCM) Services – Pupils with an IEP/IFSP Only

Definition	Targeted Case Management (TCM) services are only allowable when provided to students with an IEP/IFSP. TCM services are services furnished to assist students in gaining access to needed medical, social, educational, or other services. TCM services include the following assistance: ▪ A comprehensive assessment and periodic reassessment of a student to determine the need for medical, social, educational, or other services. These assessment activities include: ➢ Taking student history;

	➢ Identifying the student's needs and completing related documentation; and ➢ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the student. ▪ Development (and periodic revision) of a POC that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the student; ➢ Includes activities such as ensuring the active participation of the eligible student, and working with the student (or the student's parent/guardian) and others to develop those goals; and ➢ Identifies a course of action to respond to the assessed needs of the eligible student. ▪ Referral and related activities: ➢ To help an eligible student obtain needed services, including activities that help link a student with medical, social, and educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the student; ➢ Monitoring and follow-up activities; ➢ Activities and contacts that are necessary to ensure the POC is implemented and adequately addresses the student's needs, and which may be with the student, family member, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met: ♦ Services are being furnished in accordance with the student's POC; ♦ Services in the POC are adequate. If there are changes in the needs or status of the student, necessary adjustments are made to the POC and service arrangements. TCM services may be reimbursed when provided by a Designated Case Manager. Providers must maintain case records that document, for all students receiving case management services, the following: ▪ the name of the student, ▪ the dates of the case management services, ▪ name of the person providing the case management services, and ▪ the nature and content. The case record must also reflect: ▪ whether the goals specified in the POC have been achieved, ▪ whether the student has declined services in the POC, ▪ the need for, and occurrences of, coordination with other case managers,

	▪ the timeline for obtaining needed services, and ▪ a timeline for re-evaluation of the POC.
Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the POC. The Designated Case Manager must be an individual who meets one of the following criteria: ▪ A licensed RN in Michigan; ▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major (30 hours) in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of a student with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: ▪ Services for infants and toddlers who are eligible under IDEA, as appropriate; ▪ Part C of IDEA and the associated regulations; ▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provision of direct care services to students with special needs; and ▪ Provision of culturally competent services within the community being served.
Targeted Case Management Services	TCM services include: ▪ Ensuring that standard re-examination and follow-up of the student are conducted on a periodic basis to ensure that the student receives needed diagnosis and treatment; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the student receives needed diagnostic and treatment services; ▪ Ensuring that case records are maintained and indicate all contacts with, or on behalf of, a student in the same manner as other covered services; ▪ Coordinating SSP services and treatment with parents/guardians and the student; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the student needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team POC; ▪ Activities that support linking and coordinating needed health services for the student;

	▪ Providing a summary of provider, parents/guardians and student health and behavioral consultation; and ▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.
Procedure Code	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.11 SPECIALIZED TRANSPORTATION

Definition	Specialized transportation services include transport to and from the student's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service. The medical need for special education transportation must be specified in the student's IEP/IFSP/NPSP POC. Medicaid may reimburse for special education transportation when a student receives a Medicaid-covered service on the same day as the day transportation is provided. Medicaid does not reimburse for transportation provided in a regular or general education school bus. There is no additional payment for an attendant. Specialized transportation is limited to students receiving services through an IEP/IFSP.
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip.
Procedure Codes	For a complete listing of procedure codes, refer to the SSP CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Taxi and Private Vehicle Transportation	For a taxi or private vehicle transportation expense to be reimbursed, the following documentation must be on file at the ISD/LEA: ▪ Specialized transportation must be included in the IEP/IFSP/NPSP POC. ▪ A Medicaid-covered medical service must be provided on the same day as the transportation. ▪ Dates and times of each trip must be listed on the ISD/LEA trip log. ▪ Documentation from the student's physician or ISD/LEA treating the student stating the reason taxi or private vehicle transportation is required must be retained in the student's file. ▪ For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file. ▪ For ongoing transportation needs, documentation is only required once per student per school year. ▪ For one-time or occasional use transportation, documentation is required for each trip or trip period per student. The total number of trips claimed for taxi and private vehicle transportation must be included in the Special Education trip count on the LEA Cost Report. Claims must be filed through CHAMPS within one year from the date of service according to Medicaid timely filing requirements. Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a student in a prone or supine position (e.g., Ambucab).

SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

3.1 QUALITY ASSURANCE

SSP providers must have a written quality assurance plan on file. SSP costs will be reviewed/audited by MDHHS for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The POC identifies which covered services are to be provided and the service frequency, duration, goals and objectives.
- A monitoring program exists to ensure that services are appropriate, effective and delivered in a cost-effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from education services.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop POCs with all other providers (i.e., Public Health, MDHHS, Community Mental Health Services Programs [CMHSPs], Medicaid Health Plans [MHPs], Hearing Centers, Outpatient Hospitals, etc.).
- Parent/guardian and beneficiary participation exists outside of the POC team process in evaluating the impact of SSP on the educational setting, service quality and outcomes.

3.2 SERVICE COORDINATION AND COLLABORATION

Students with special needs have access to services available in both outpatient and school-based treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct. SSP services are provided to assist a student with a disability to benefit from special education. Outpatient services are provided to optimize the student's functional performance in relation to needs in the home or community setting and must not duplicate those provided in the school setting. Collaboration between the school and community providers is mandated to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, or participation in team meetings such as the IEP/IFSP meeting and POC development. If coordination cannot be established, the ISD/LEA should retain documentation of their coordination attempts.

3.3 ISD Responsibilities

Each ISD must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy, and completeness of the Random Moment Time Study (RMTS) sample frame (designated employees), adherence to MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim or final settlement of the Medicaid LEA cost report.

3.3.A. Sanctions

It is the intent of the State to pursue, when necessary, remedial action or implement a corrective action plan if the ISDs or their vendors are not in compliance with Medicaid policy and procedures. If these actions are not successful, a payment freeze will be implemented, and sanctions put in place until the matter is resolved. ISDs are responsible for the actions of their vendors.

The following are examples of causes for sanctions. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Claims Development Contractor.
- Failure to submit requested information, reports, or data to the State Claims Development Contractor, CMS, MDHHS, MDE, or MiLEAP, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through CHAMPS.

SECTION 4 – PROVIDER ENROLLMENT

4.1 ENROLLMENT

The 56 Michigan Intermediate School Districts (ISDs) and their associated local education agencies (LEAs), Detroit Public Schools Community District (DPSCD), and Michigan School for the Deaf (MSD) are the only providers eligible to bill Medicaid for SSP services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

4.2 CERTIFICATION OF QUALIFIED STAFF

MDE must provide MDHHS with documentation that enrolled ISDs meet the regulatory requirements set forth for all staff providing services in the school setting.

Enrollment as a provider is predicated on certification to MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) who may be performing claimable activities have been met and are current. MDE will assist any ISD/LEA in this certification process and verify the status of its certification in writing, along with recommendations, with a copy sent to MDHHS.

4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual direct medical and behavioral health services activities that occur in an ISD/LEA on any given day. Since these services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what services are being provided. For this reason, it is necessary to calculate two separate Medicaid eligibility rates.

4.3.A. C4S MEDICAID ELIGIBILITY RATE (MER)

The C4S Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the public student population that are Medicaid eligible in each ISD in comparison to the total student population in the ISD. The eligibility rate is determined once each year utilizing the Student Count Report. The calculation for the C4S eligibility rate is as follows:

$$\frac{\text{Medicaid Eligible Students}}{\text{Total Student Population}}$$

4.3.B. DSC MER

The DSC MER percentage is determined by the percentage of the special education student population with a health-related support service in their IEP/IFSP/NPSP that are Medicaid eligible in each ISD in comparison to the total special education student population with a health-related support service in the ISD. The MER is determined once each year utilizing the Student Count Report. The calculation for the DSC eligibility rate is as follows:

$$\frac{\text{Medicaid eligible Special Education Students with a health-related support service in their IEP}}{\text{Total Special Education Students with a health-related support service in their IEP}}$$

SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

5.1 FINANCIAL DATA

The financial data reported for Direct Medical Services (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system and be directly attributable to staff that are included on the staff pool lists. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs are to include actual non-federal expenditures incurred during the claiming period. These allowable expenditures include such things as salaries, wages, fringe benefits, medically-related supplies, purchased services and materials.

5.2 UNALLOWABLE COSTS

Providers are not allowed to report any costs that are federal funds, State flow-through funds, or non-federal funds that have been committed as local match for other federal or State funds or programs.

Claims for approved Medicaid SSP functions may not include expenditures of:

- Federal funds received by the ISD/LEA directly
- Federal funds that have been passed through a State or local agency
- Non-federal funds that were previously committed as local match for other federal or State funds or programs

Funds received by an ISD for SSP direct medical services are not federal funds. These funds are reimbursement for prior expenditures and become, upon receipt, local funds.

SECTION 6 – SCHOOL SERVICES PROGRAM REIMBURSEMENT

6.1 METHOD OF REIMBURSEMENT FOR DIRECT MEDICAL SERVICES, PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

Payment for Michigan's SSP is a cost-based, provider-specific, annually reconciled, and cost settled reimbursement methodology.

CMS also requires Michigan SSP providers to submit procedure-specific direct medical services claims for all Medicaid allowable services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the student, and provide an audit trail. Interim monthly payments are tied to the submission of the direct medical services claims. If claim volume decreases significantly or drops to zero in any two consecutive months, all interim payments will be held until the provider is contacted and the issue resolved. MDHHS will monitor provider claim volume to make sure that this mandate is followed.

Claims are submitted and processed through CHAMPS; however, the procedure code fee screens are set to pay zero. SSP providers receive their cash flow from the interim monthly payment process described below.

The interim monthly payments are based on prior year actual costs and reconciled on an annual basis to the current year costs. Cost reporting and reconciliation are based on the school fiscal year which is July 1 through June 30 of each year.

The reimbursement process for direct medical services is comprised of the following parts:

- The SSP direct medical services procedure code-specific billing process;
- The RMTS component;
- The interim payment process; and,
- The cost reconciliation and cost settlement process.

6.1.A. DIRECT MEDICAL SERVICES PROCEDURE CODE-SPECIFIC BILLING

Providers must continue to submit procedure-specific claims in addition to the expenditure reports. The procedure-specific process is described in the Covered Services Section of this chapter.

Claim documentation must be sufficient to identify the student clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be adequate to demonstrate that the service was provided and that the service followed the student's POC.

The ISD may either purchase software for the claims submission function or it may utilize the services of a billing agent. The cost of claim submission is the responsibility of the ISD.

6.1.B. Random Moment Time Study (RMTS)

For the RMTS, all ISDs are required to utilize the services of the State Contractor who will conduct the statewide time studies.

The quarterly RMTS sampling results are produced by the State Contractor who converts the results to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.

Costs are reported for direct medical services and specialized transportation services on the LEA Cost Report and collected via financial worksheets for PCS and TCM.

The MDHHS Hospital and Clinic Reimbursement Division combines all cost information and the RMTS results, the indirect cost rate, and the MER to calculate the total allowable costs. The MDHHS Hospital and Clinic Reimbursement Division performs the reconciliation and cost settlement process.

The ISD and/or State Contractor must comply with all conditions set forth by MDHHS as SSP policy.

The cost for the State Contractor is charged back to the ISDs based on the State Contractor's projected cost per ISD (after federal match).

For detailed description and instructions regarding the Random Moment Time Study, refer to the School Services Program Random Moment Time Study Appendix of this chapter.

Summer Quarter Process

A weighted average of the three time study results for the staff pool periods listed below is applied to the LEA Cost Report total costs. The LEA Cost Report costs include the annual costs associated with the direct medical services, PCS, and TCM services.

The direct medical services time study application is comprised of the following elements:

Cost Pool	The costs from the annual LEA Cost Report (direct medical services, TCM, and PCS).
RMTS	A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

6.1.C. Interim Payment Process

Interim payments are calculated based on an estimated monthly cost formula. The monthly cost formula utilizes prior year costs plus any inflation or program changes to calculate a monthly interim reimbursement amount. After the final cost reports have been reviewed and reported to MDHHS, reconciliation will be performed and settlements will be made to make the ISDs whole.

Interim payments are issued on the first pay cycle of each month based on prior year costs.

To justify an increase in the interim payment, ISDs must submit written documentation of significant changes in coverage, service utilization or staff costs.

ISDs may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the LEA Cost Report. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to ISDs, how the interim payment revenue is distributed to the respective LEAs and how the initial and final settlements are handled is at the discretion of the ISD.

6.1.D. Cost Reconciliation and Settlement

Allowable cost will be based on the following components:

- Costs from the LEA Cost Report
- TCM and PCS Financial Worksheets
- MDE Indirect Cost Rate
- RMTS Percentage
- Health-Related IEP Medicaid Eligibility Rate (IEP MER)
- Federal Medical Assistance Percentage (FMAP)

Allowable costs (LEA Cost Report and financial worksheets for TCM and PCS)	X	Indirect Cost Rate	X	Annual average % time claimable to Medicaid from the time studies	X	Discounted by the Medicaid eligibility rate	X	% Federal Medical Assistance Percentage (FMAP) rate	=	Medicaid reimbursement amount

The LEA Cost Report is utilized to collect allowable costs for the medical professional staff. Costs for staff providing TCM services and PCS that are not included in the direct medical costs are obtained from the participating ISD's financial accounting system via financial information submitted by the ISD/LEA.

To report direct service-related costs, ISDs will utilize the LEA Cost Report. The LEA Cost Report is available in CHAMPS within the Facility Settlement (FS) subsystem. Documentation and instructions are available by accessing the information button and worksheets within the FS subsystem. Worksheets may be extracted through an Excel extract at any time. After submission of the LEA Cost Report, the ISD shall review and approve the submission. Once approved, the ISD may calculate the ISD Cost Report

which, using the LEA Cost Reports, will compile and calculate the data used to reimburse for SSP costs. Access and authorization are administered through CHAMPS and also maintained through MiLogin user access. MILogin registration instructions are also available on the SSP Provider Specific webpage. (Refer to the Directory Appendix for website information.)

The filed cost data is used to calculate an initial settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over- or under-adjustment to the provider interim payment.

The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion.

ISDs may submit revisions until the final settlements are processed.

6.2 Method of Reimbursement for Specialized Transportation

6.2.A. Reimbursement

Specialized transportation costs reported on the MDE Transportation Expenditure Report (form SE-4094) are only the costs associated with the special education buses, taxis or private vehicles used for the specific purpose of transporting only special education children. This report does not include any federal dollars.

Medicaid-allowable specialized transportation costs include the following costs from the SE-4094:

- Salaries [Sec. 52 & Sec. 53a]
  - Bus Drivers
  - Aides
  - Employee Benefits (Bus Drivers and Aides only)
- Purchased Services – Staff (Bus Drivers and Aides only)
- Purchased Services – Vehicle-Related Costs [Sec. 52 & Sec. 53a]
  - Pupil Transportation by Carrier
  - Pupil Transportation by Carrier (b/y)
  - Family Vehicle Cost
  - Contracted Taxis
  - Pupil Transportation Fleet Insurance
  - Contracted/Leased Buses
- Supplies [Sec. 52 & Sec. 53a]
  - Gasoline/Fuel
  - Oil/Grease

- Tires/Batteries
- Other Expense/Adjustments, only the costs associated with adjustments to allowable costs
- Bus Amortization

For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's IEP/IFSP.

6.2.B. Specialized Transportation Reconciliation and Settlement

On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from CHAMPS to arrive at the Medicaid allowable cost.

An "allowable" one-way trip is one that is provided to a Medicaid-eligible student and fulfills all of the following requirements:

- Documentation of ridership is on file;
- The need for the specialized transportation service is identified in the student's IEP/IFSP; and
- A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid-covered service must also be documented in the IEP/IFSP.

The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for specialized transportation is combined with the cost settlement amounts for Direct Medical Services, TCM, and PCS; any over-/under-adjustments are processed as one transaction.

SECTION 7 – INDIRECT COST RATE (ICR)

7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each ISD is approved by the Federal cognizant agency. The indirect cost rates are updated annually by MDE.

SECTION 8 – COST CERTIFICATION

8.1 COST CERTIFICATION

Once all cost reports and financial worksheets have been received by MDHHS, the summary report of the LEA Cost Report will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for annually certifying that the total amount of expenditures for covered services has been expended and that none of the expenditures were used as match for other programs or services. This is accomplished in CHAMPS when submitting cost in the LEA Cost Report or may be submitted manually if requested by the State of Michigan.

SECTION 9 – COST ALLOCATION FACTORS

9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) RATE

Federal regulations allow for payments to states on the basis of a FMAP for part of their expenditures for services under an approved State Plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act. Under the formula:

- If a state's per capita income is equal to the national average per capita income, the federal share is 55%.
- If a state's per capita income exceeds the national average, the federal share is lower, with a statutory minimum of 50%.
- If a state's per capita income is lower than the national average, the federal share is increased, with a statutory maximum of 83%.

9.2 ALLOCATION OF SALARIES AND BENEFITS OF PERSONNEL PROVIDING DIRECT CARE SERVICES

Actual expenditures for salaries and benefits of all personnel are to be obtained from each participating ISD's financial accounting system. Expenditures related to the performance of approved Medicaid contracted service providers (e.g., OTs, PTs) who also provide direct care services must also be obtained from each participating ISD's financial accounting system.

SECTION 10 – DOCUMENTATION

10.1 DIRECT MEDICAL SERVICES DOCUMENTATION

For covered services, the student's school clinical record must include all of the following:

- Student name and birth date;
- Attendance records, confirming that services requiring the student to be in attendance have supporting documentation on file;
- Date of service/treatment;
- Type (modality) of service/treatment;
- The response to the service/treatment; and
- The name and title of the person providing the service/treatment and a dated signature, including electronic signature.

For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the student's school clinical record. The record must indicate the specific findings or results of the diagnostic or therapeutic procedures. The student's school clinical record should include documentation of the implementation and coordination of services for the special education student.

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment, with rationale for change when determined to be necessary.

(Refer to the General Information for Providers Chapter of this manual for additional information regarding clinical record requirements.)

10.2 RMTS DOCUMENTATION

Each participating ISD/LEA must maintain a separate audit file for each quarter billed. The following minimum documentation is required:

- Financial data generated by the ISD/LEA's financial accounting system to establish cost pools and factors.
- A copy of the quarterly sample results produced by the State Contractor.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that payment from MDHHS was received.

ISDs/LEAs must cooperate fully with any reviews requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years.

Any changes in federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

SECTION 11 – AUDIT AND RECOVERY PROCEDURES

11.1 DIRECT SERVICE/TRANSPORTATION PROGRAM AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS AUDIT DIVISION

MDHHS audit review of selected ISD cost reports for the SSP may include the following activities:

- Verification that the LEA Cost Report accurately reports the allowable costs incurred for the appropriate period.
- Verification that the salaries and benefits listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries and benefits of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the LEA Cost Report staff pool list was reported, and that salaries and benefits for both the original and replacement employees were not duplicated on the report for the same time period.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. Employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on LEA Cost Reports and that LEA Cost Report costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD should be prepared to direct the auditor to any document used to support and identify the reported LEA Cost Report costs.

11.2 STUDENT CLAIMS AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS AUDIT DIVISION

MDHHS audit review of selected ISDs for approved SSP student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual.
- Verification that occupational, physical, and speech, language and hearing therapy address a student's medical need that affects their ability to learn in the classroom environment.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.

- Verification that the providers requiring supervision, both "under the direction of" and "under the supervision of", have the necessary support documentation on file.
- Verification that the student receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation.
- Confirmation that support documentation for PCS includes a completed, signed and dated monthly activity log.
- Verification that group therapy or treatment was provided in groups of two to eight, including noting the specific number of students in the group therapy session.
- A standard review of the POC areas, such as the inclusion of a description of the student's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the student's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals.
- Any other area deemed necessary.

The ISD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

11.3 Audit Activities to be Performed by MDHHS Audit Division Staff

MDHHS audit review of selected ISD cost reports for the Administrative Outreach Program (AOP) may include the following activities:

- Verification that the salaries and benefits listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries and benefits of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries and benefits for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries, benefits, and costs for supplies, etc. are of direct benefit to the employees on the staff pool list and, therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. Employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.

- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

11.4 Audit Findings and Resolution

Audit findings and resolution will include the following:

- Identified overstatement of expenditures on the LEA Cost Report will require the revision of the LEA Cost Report and a revised final settlement for all specifically identified overstatements.
- For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.

SCHOOL SERVICES PROGRAM ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT APPENDIX

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SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDHHS will select one State Claims Development Contractor to implement and administer the random moment time study (RMTS). The State Claims Development Contractor will also provide the intermediate school districts (ISDs) the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs that choose to participate in this portion of the State contract and pay for these services.

1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All participating ISDs will be required to utilize the services of the State Claims Development Contractor, who will conduct statewide time studies and develop and submit claims on the ISD's behalf each quarter.

The State Claims Development Contractor will develop an implementation plan on behalf of the ISDs to conduct the statewide time studies each quarter utilizing the claims development software, as well as complete all other key functions required for valid claim development.

The cost for the State Claims Development Contractor will be charged back to providers who participate in this option based on the State Claims Development Contractor's projected cost per ISD (after federal match).

1.2 OVERVIEW OF CLAIMS DEVELOPMENT PROCESS

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of SSP Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State Claims Development Contractor utilizing the claims development software following these basic steps:

- The quarterly RMTS sampling results are produced by the State Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement.
- The cost/claim generation component of the claims development software uses ISD costs and other claim factors to calculate and produce the claim.
- The claim is submitted to MDHHS.
- The ISD or ISD contractor must comply with all conditions set forth by MDHHS as School Services Program (SSP) policy.

SECTION 2 - CLAIM CALCULATIONS

2.1 SANCTIONS

It is the intent of the State Medicaid Agency to pursue, when necessary, remedial action or implement a corrective action plan if the State Claims Development Contractor or the ISD are not in compliance with SSP Administrative Outreach Program published policy. If this is not successful, a contract payment freeze will be implemented, and sanctions will be put in place until the matter is resolved. Those independent ISDs not participating in the State's claims development contract will be held accountable for their vendor's actions.

The following are examples of causes for implementation of sanctions for all ISDs. The list is not all-inclusive.

- Failure to complete minimum threshold of sampled moments each quarter.
- Repeated errors in filing of the claims.
- Providing insufficient data or incomplete reports to the State Claims Development Contractor.
- Failure to cooperate with, or submit requested information, reports, or data to, the State Claims Development Contractor, CMS, MDHHS, MDE, and other staff involved during site visits, reviews or audits.

2.2 FACTORS FOR CLAIMS DEVELOPMENT

MDHHS will submit quarterly claims on behalf of all participating ISDs to CMS. Each claim will be based on the following factors: The allowable financial expenditures, percentage of time claimable to SSP Administrative Outreach Program administration, the Federal Financial Participation (FFP) rate, the Medicaid indirect cost rate, and the Medicaid eligibility rate for that individual ISD.

2.2.A. ALLOWABLE FINANCIAL EXPENDITURES

These expenditures consist of the actual costs incurred for the quarter being claimed, such as salaries, benefits, and contracted staff costs for staff included in RMTS staff pools for the corresponding time period. Each participating ISD must certify that the claim submitted to MDHHS contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

2.2.B. FEDERAL FINANCIAL PARTICIPATION RATE

Federal regulations allow for a reimbursement rate of 50 percent for most Medicaid administrative activities. (Note that Medicaid-related translation has a 75 percent FFP.)

2.2.C. MEDICAID ELIGIBILITY RATE

The Medicaid eligibility rates (MER) are determined by the percentage of the population in each ISD who are actual Medicaid beneficiaries. The MER will be determined once each year and applied to certain activities in the claim calculation formula. To calculate the MER, the claiming entity will obtain the Fall pupil count report list from the Center for

Educational Performance and Information (CEPI). The pupil count list will include the pupil's name and date of birth. MDHHS will provide a method for using the list to verify the number of Medicaid-eligible pupils. This number will be used in a calculation with the total pupil count to determine the percentage of Medicaid-eligible pupils in the ISD.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims

Allowable Financial Expenditures, Including Indirect Costs (salaries, overhead, etc.)	X	% time claimable for Medicaid outreach activities from time studies	X	Discounted by the Medicaid eligibility rate (MER)	X	% Federal Financial Participation (FFP) rate	=	The amount of the claim submitted for Medicaid reimbursement

Summer Quarter Formulas

Allowable Financial Expenditures, Including Indirect Costs (salaries, overhead, etc.)	X	Average % of time claimable for Medicaid outreach activities from the previous three quarters	X	Discounted by the Medicaid eligibility rate (MER)	X	% Federal Financial Participation (FFP) rate	=	The amount of the claim submitted for Medicaid reimbursement

- Salary and related costs of all staff eligible for the time study are included in the cost pool, along with other allowable overhead.

2.3 Financial Data

The financial data reported on employee basis (salaries, benefits, contracted staff costs, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to be reported using cash-basis accounting. Include only actual expenditures incurred during the claiming period.

2.4 RMTS Documentation and Recordkeeping/Audit File Requirements

Each participating ISD will maintain a separate audit file for each quarter billed. The following minimum documentation is required:

- Financial data used to establish cost pools and financial data at the employee level with accounting detail.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that reimbursement from MDHHS was received.

ISDs must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records and supporting documentation for a minimum of seven (7) years after submission of each quarterly claim.

2.5 Non-Pupil Specific/Pre-Medicaid Eligibility Determination

Additional Administrative Outreach activities and expenditures not related to a specific pupil are approved by Medicaid for claiming. These activities are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual pupils, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid Administrative Outreach claim based on the results of the time study conducted during the claiming period.

2.6 Pupil-Specific Administrative Outreach Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual pupils after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted MER.

2.7 Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid Administrative Outreach activities may be included in the claim if they can be attributed directly to staff members who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Title 2 CFR Part 225, must be followed. Examples include conference fees, registration fees, mileage, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD's financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

2.8 Indirect Costs

Allocable indirect costs are the product of the ISD aggregate, calculated, approved Medicaid Administrative Outreach claim amount, multiplied by the ISD and LEA Medicaid indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA Medicaid indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 225. The methodology used to determine the indirect cost rate is specific to each ISD, as approved by the Federal cognizant agency. Indirect cost rates are updated annually by MDE.

2.9 Claim Certification

The accuracy of submitted claims must be certified by the chief financial officer, the superintendent of the ISD, or the ISD designee. Such certification is accomplished when the quarterly claim meets the requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD for audit or future reference purposes according to the terms identified in the State Claims Development Contractor and interagency agreement between the ISD and MDHHS.

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.

2.10 Claim Amendments

In the event that an error in the claim process has been identified, it is the responsibility of the ISD to notify the State Claims Development Contractor. The State Claims Development Contractor will open an amendment to the quarterly claim for which the error was identified. The ISD will correct the error by amending the previously filed financial data. After the data is submitted, a new claim will be calculated for the period. The ISD will review and certify the claim using the same process as the original submission. The adjustment will be filed with the next claim submission to MDHHS and the adjustment will be processed with the current quarterly submission. The current reimbursement will reflect the current reimbursement and any adjusted reimbursements.

2.11 Fiscal Provisions

ISDs must use an appropriate revenue code to identify Medicaid Administrative Outreach Program funds within their accounting records.

2.12 Submission of Claims

All claims are to be submitted in accordance with the reporting requirements established by MDHHS. It is imperative that ISDs work closely with the State Claims Development Contractor to provide pertinent financial, enrollment, and personnel data and meet their deadlines and any other technical specifications.

2.13 Periodicity of Reporting

The ISD must submit claims for expenditures related to approved Medicaid Administrative Outreach activities to MDHHS on a quarterly basis. The claim is due to MDHHS on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDHHS

	REPORTING PERIOD		CLAIM DUE TO MDHHS	CLAIM SUBMITTED TO CMS BY MDHHS
	BEGIN DATE	ENDING DATE		
Summer	July 1	September 30	January 28	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 29	September 30
Spring	April 1	June 30	October 28	December 31

SCHOOL SERVICES PROGRAM RANDOM MOMENT TIME STUDY APPENDIX

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SECTION 1 – GENERAL TIME STUDY INFORMATION

This chapter describes the random moment time study (RMTS) process for the School Services Program (SSP) direct medical services program.

In accordance with the Centers for Medicare & Medicaid Services (CMS) reimbursement policy, some activities performed by medical professionals and Intermediate School District (ISD) staff in a school-based setting are eligible for federal matching funds. These activities may be performed by staff with multiple responsibilities. CMS reimbursement requirements include the use of RMTS as a component of the Medicaid reimbursement methodology. The time study results are used to determine the amount of staff time spent on Medicaid-allowable activities. One statewide time study per staff pool is performed each quarter.

1.1 ADMINISTRATIVE OUTREACH PROGRAM ACTIVITIES

The School Services Program Administrative Outreach Program (AOP) offers reimbursement for the cost of administrative activities that support efforts to identify and enroll potentially eligible students into Medicaid and that are in support of the state Medicaid plan.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determinations
- Health-related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Transportation and Translation Services

1.2 DIRECT MEDICAL SERVICES

Medicaid-covered services that are medically necessary and specified in the beneficiary's Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), Non-Public Service Plan (NPSP), or other plans in which medical necessity has been established include:

- Occupational Therapy Services
- Orientation and Mobility Services
- Physical Therapy Services
- Assistive Technology Device Services
- Speech, Language and Hearing Services
- Psychological, Behavioral Health, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services

- Physician and Psychiatric Services
- Personal Care Services
- Targeted Case Management Services (Direct Service Claiming [DSC] only)

1.3 Staff Pools and Confidence Levels

The RMTS is carried out utilizing customized claims development software that automates aspects of the school district time study process. The claims development software is comprised of three components: sampling/staff pool lists, training, and cost/claim generation. All ISDs are required to utilize the services of the State's RMTS and Claims Development Contractor (hereafter referred to as the Contractor). The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools Community District (DPSCD) and Michigan School for the Deaf (MSD) [hereafter referred to as "ISDs"].

Time studies will be carried out over the following staff pools:

- AOP Only Staff – This staff pool consists of individuals who perform only administrative outreach activities. They do not perform any direct medical activities.
- AOP & Direct Medical Staff – This staff pool consists of individuals who perform both direct medical activities and AOP activities.
- Personal Care Services Staff – This direct medical only staff pool consists of individuals who perform direct care Personal Care Services.
- Targeted Case Management Services Staff – This direct medical only staff pool consists of individuals who perform Targeted Case Management (TCM) Services and pertains to the DSC component of the program only.

The RMTS results identifying the percentage of claimable time are applied to the allowable correlating cost pool. All staff pools are mutually exclusive.

The sample size of each cost pool ensures a quarterly level of precision of +/- 2 percent with at least a 95 percent confidence level, and an annual level of precision of +/- 2 percent with at least a 95 percent confidence level.

Valid moments are completed moments that have been received by the Contractor and determined to be complete and accurate. Invalid moments are moments that are assigned to staff who are no longer in the position as selected, moments that are outside of paid work hours, and moments not returned for any other reason.

As long as the completed observation rate meets or exceeds 85 percent, missing observations will be dropped from all calculations. Should the completion rate fall below 85 percent, missing observations will be included as non-matchable.

SECTION 2 – CENTRALIZED CODING

The Contractor is responsible for coding the time study moments. MDHHS oversees the Contractor and ISDs participating to ensure their compliance with all aspects of program policy and federal regulations.

SECTION 3 – TIME STUDY METHODOLOGY

3.1 RANDOM MOMENT TIME STUDY OVERVIEW

The time study design logs only what the participant is doing at one moment in time. A random moment consists of one minute of work done by one employee, both chosen at random, from among all such minutes of work that have been scheduled for all designated staff statewide.

The RMTS measures the work effort of each group of approved participants involved in the time study process by sampling and analyzing the work efforts of a randomly selected cross-section of each staff pool. The RMTS methodology employs a technique of polling participants at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the three-month period comprising each federal quarter of the year, except for the summer quarter (July through September) which uses the RMTS averages of the other three quarters.

The Contractor will use the claims development software to conduct the statewide time studies each quarter. This software produces random moments concurrent with the entire reporting period which are then paired with randomly selected participants of the designated staff pool population. The sampling is constructed to provide each participant in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other participant to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

3.1.A. LONG-TERM SUBSTITUTES

Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized:

- A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter.
- The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed.
- The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid School Services Program staff pool.
- If listed on the staff pool list, the substitute staff must complete the time study moment.
- The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.

- All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity.
- All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

3.2 Random Moment Time Study Form Completion

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to the questions. These questions relate to their activities at the time of their randomly selected moment.
- In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the study questions.

The Contractor conducts the statewide time studies each quarter for all ISDs and produces a report detailing the results. This involves importing clinician information from the ISDs to compile the statewide pool of all eligible time study participants for each staff pool list. There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. Currently, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The State and the Contractor review compliance every quarter and may adjust sample sizes as necessary for compliance purposes. The participant's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.

The Contractor monitors the status of each time study form so that appropriate follow-up emails are made for delinquent moments or missing data. The ISD is responsible for monitoring time study completion. The time study is electronically completed in the Contractor's system. At the end of the sampling period after all data has been collected and tabulated, statistical validity reports will be produced by the Contractor. These reports will verify that a sufficient number of personnel were sampled to ensure time study results that have a confidence level of at least 95 percent quarterly, with a precision level of +/- 2 percent annually.

3.3 Time Study Staff Pools

To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor.

If staff pool lists or financials for the Direct Services, the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the ISD/LEA staff pool lists and correlating financials will

be removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

When providing the staff pool list of those eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate participants are submitted and that appropriate credentials are in place for billing Medicaid.

3.3.A. AOP Only Staff Pool

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Teacher Consultants
- Direct Medical Personnel who do not meet the Medicaid qualifications for direct medical service claiming

3.3.B. AOP & Direct Medical Services Staff Pool

AOP & Direct Medical Services Staff Pool:

- Fully-Licensed Speech-Language Pathologists
- Limited-Licensed Speech-Language Pathologists under the direction of a Fully-Licensed Speech-Language Pathologist
- Limited-Licensed Speech-Language Pathologists in their Clinical Fellowship Year under the direction of a Fully-Licensed Speech-Language Pathologist
- Audiologists
- Licensed Professional Counselors
- Limited-Licensed Professional Counselors under the supervision of a Licensed Professional Counselor
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Board Certified Behavior Analysts
- Board Certified Assistant Behavior Analysts
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Physician Assistants

- Nurse Practitioners
- Clinical Nurse Specialists
- MDE Credentialed School Psychologist
- Fully-Licensed Psychologists
- Limited-Licensed Psychologists under the supervision of a Fully-Licensed Psychologist
- Temporary Limited-Licensed Psychologists under the supervision of a Fully-Licensed Psychologist
- Registered Nurses
- Qualified School Nurses as defined by Public Health Act 269 of 1955 as amended
- Licensed Practical Nurses
- Marriage and Family Therapists
- Licensed Master's Social Workers
- Limited-Licensed Master's Social Workers under the supervision of a Licensed Master's Social Worker

3.3.C. Personal Care Services Staff Pool

The following staff may be appropriate for inclusion in time studies if they are involved in Personal Care activities in the school setting:

- Bilingual Aides
- Health Aides
- Instructional Aides
- Paraprofessionals
- Program Assistants
- Teacher Aides
- Trainable Aides
- Behavioral Health Aides

3.3.D. Targeted Case Management Services Staff Pool – Pupils with an IEP/IFSP/NPSP Only

Staff with appropriate credentials, as defined in the Targeted Case Management (TCM) Services – Pupils with an IEP/IFSP Only subsection of the School Services Program Chapter, may be appropriate for inclusion in time studies if they are involved in Targeted Case Management activities in the school setting. Targeted Case Management services are only allowable when provided to students with an IEP/IFSP/NPSP.

SECTION 4 – ADMINISTRATIVE OUTREACH AND DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the code categories utilized for the RMTS and indicates whether they are claimable for reimbursement under the AOP only, the AOP & Direct Medical Services program (including Personal Care Services and Targeted Case Management Services), allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities are those that are purely educational in nature.

These codes represent activities that may be performed by any time study participants during a typical workday. Some of these activities may be claimed under Medicaid and some may not. In the following section, examples and clarifications of each code are provided to assist with the appropriate coding of the activities.

4.1 ACTIVITY CODES

Staff Activity and Codes – the indicators below, which follow each code, provide the application of the Federal Financial Participation (FFP) rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the code. In order to maintain coding objectivity by time study participants, time study sheets used by participants should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable or unallowable under Medicaid.

Application of FFP Rate	
50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
75 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 75 percent enhanced FFP rate.
Unallowable Activities	
U	Refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
Application of Medicaid Share	
TM	(Total Medicaid) Refers to an activity that is 100 percent allowable as administration under the Medicaid program.
PM	(Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allowable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid eligibility rate [MER] or the IEP Ratio). The Medicaid share is then determined by applying the MER or the IEP Ratio to the appropriate pupil populations.

Reallocated Activities	
R	Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10 - General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved unrestricted indirect cost rate.*

4.2 Uniform Codes

State contractor staff should document time spent on each of the following coded activities:

Code 1.a.	Non-Medicaid Outreach – U
Code 1.b.	Medicaid Outreach – TM/50 Percent FFP
Code 2.a.	Facilitating Application for Non-Medicaid Programs - U
Code 2.b.	Facilitating Medicaid Eligibility Determination – TM/50 Percent FFP
Code 3.	School Related and Educational Activities – U
Code 4.a.	Direct Medical Services – Not Covered on a Medical Plan of Care (FFS – Non-IEP) - U
Code 4.b.	Direct Medical Services – Covered as IDEA/IEP Services (FFS – IEP) - IEP Ratio
Code 4.c.	Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service – Medical Plan Ratio
Code 5.a.	Transportation for Non-Medicaid Services – U
Code 5.b.	Transportation-Related Activities in Support of Medicaid Covered Services – PM/50 Percent FFP
Code 6.a.	Non-Medicaid Translation – U
Code 6.b.	Translation Related to Medicaid Services – PM/75 Percent FFP
Code 7.a.	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services – U
Code 7.b.	Program Planning, Policy Development and Interagency Coordination Related to Medical/Medicaid Services – PM/50 Percent FFP

*Moments from Code 10. General Administration are reallocated to codes 1.b., 2.b., 5.b., 6.b., 7.b., 8.b. and 9.b. proportionally for the Administrative Outreach Program Claim. Moments from Code 10. are also proportionally reallocated to codes 4.b. and 4.c. for the annual cost report.

Code 8.a.	Non-Medical/Medicaid Training – U
Code 8.b.	Medical/Medicaid Related Training – PM/50 Percent FFP
Code 9.a.	Referral, Coordination, and Monitoring of Non-Medicaid Services – U
Code 9.b.	Referral, Coordination, and Monitoring of Medicaid Services – PM/50 Percent FFP
Code 10.	General Administration – R
Code 11.	Not Scheduled to Work- Not Included in the distribution or invalid

4.2.A. Code 1.a. - Non-Medicaid Outreach – U

This code should be used for all ISD/LEA staff when performing activities that inform individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Includes related paperwork, clerical activities, and staff travel required to perform these activities.

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate students about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage students to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of students with special medical/dental/mental health needs through various child find activities.
- Outreach activities in support of programs that are 100 percent funded by State general revenue.
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

4.2.B. Code 1.b. - Medicaid Outreach – TM/50 Percent FFP

This code should be used for staff performing activities that inform eligible or potentially eligible students about Medicaid and how to access it. Activities include bringing potentially eligible students into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. ISDs/LEAs may only conduct outreach for the populations served by their affiliated schools, i.e., students and their parents or guardians. Examples include:

- Informing Medicaid eligible and potentially Medicaid eligible students and their parents or guardians about the benefits and availability of services provided by Medicaid (including preventive treatment and screening), including services provided through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. NOTE: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school-developed outreach materials should have prior approval of the Medicaid agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their parents or guardians about health resources available through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting students about the availability of Medicaid prenatal and well-baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to students and their parents or guardians and how to access that system.
- Encouraging parents or guardians to access medical/dental/mental health services provided by the Medicaid program.

Activities which are not considered Medicaid outreach under any circumstances are: (1) general preventive health education programs or campaigns addressing lifestyle changes, and (2) outreach campaigns directed toward encouraging individuals to access social, educational, legal or other services not covered by Medicaid.

4.2.C. CODE 2.A. - FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

This code should be used for staff when informing a student or their parents or guardians about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Women, Infants, and Children (WIC), day care, legal aid and other social or educational programs and referring them to the appropriate agency to make application. The following are examples:

- Explaining the eligibility process for non-Medicaid programs, including IDEA.
- Assisting the student or their parents or guardians in collecting/gathering information and documents for the non-Medicaid program application.
- Assisting the student or their parents or guardians in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.

- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

4.2.D. Code 2.b. - Facilitating Medicaid Eligibility Determination - TM/50 Percent FFP

This code should be used for staff when assisting a student in becoming eligible for Medicaid. Includes related paperwork, clerical activities, and staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility. Examples include:

- Verifying a student's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting student or their parents or guardians in completing a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for a student, including resource information and third-party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring a student or their parents or guardians to the local assistance office to make application for Medicaid benefits.
- Assisting the student or their parents or guardians in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation (does not include determining eligibility).

4.2.E. Code 3. - School Related and Educational Activities – U

This code should be used for any other school related activities that are not health related, such as social services, educational services and teaching services, employment and job training. These activities include the development, coordination and monitoring of a student's education plan. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Providing classroom instruction (including lesson planning).
- Testing or correcting papers.
- Developing, coordinating, and monitoring the academic portion of the IEP for a student, which includes ensuring annual reviews of the IEP are conducted, parental or guardian signoffs are obtained, and the academic portion of the actual IEP meetings with the parents or guardians. (If appropriate, this would also refer to the same activities performed in support of an IFSP or NPSP.)

- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, and student-focused areas.
- Reviewing the education record for students who are new to the school district.
- Providing general supervision of students (e.g., playground, lunchroom).
- Monitoring student academic achievement.
- Providing individualized instruction (e.g., math concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.
- Carrying out discipline.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the educational aspects of meeting immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with student or their parents or guardians about discipline, academic matters or other school related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.

4.2.F. Code 4.a. - Direct Medical Services – Not Covered on a Medical Plan of Care (FFS – Non-IEP) - U

This code should be selected when ISD/LEA staff members (employees or contracted staff) are providing direct student care services for which medical necessity has not been determined. This code includes pre- and post-activities associated with the actual delivery of the direct student care services, e.g., paperwork or staff member's travel required to perform these services.

Examples of activities reported under this code:

- All non-IDEA and/or non-IEP direct student care services as follows:
  - Administering first aid
  - Screening services conducted by non-qualified providers
  - Mental health services conducted by non-qualified providers
  - Nursing services conducted by non-qualified providers

4.2.G. Code 4.B. - Direct Medical Services – Covered as IDEA/IEP Service (FFS – IEP) – IEP Ratio

This code should be selected when ISD/LEA staff members (employees or contracted staff) provide direct student services as covered services delivered by ISDs/LEAs under the Fee for Service (FFS) Program for students with an IEP/IFSP/NPSP. These direct student services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e., health-related) services. It also includes functions performed pre- and post-actual direct student services (when the student may not be present); for example: paperwork, or staff travel directly related to the direct student services.

Examples of activities reported under this code:

4.2.G.1. All IDEA/IEP Direct Student Services With the Student Present

Includes:

- Providing health/mental health services as covered in the student's IEP/IFSP/NPSP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP/IFSP/NPSP.

4.2.G.2. Direct Medical Services Cost Pool

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the student's IEP/IFSP/NPSP).
- Physical Therapy services and evaluations (only if included in the student's IEP/IFSP/NPSP).
- Occupational Therapy services and evaluations (only if included in the student's IEP/IFSP/NPSP).
- Speech/Language Therapy services and evaluations (only if included in the student's IEP/IFSP/NPSP).
- Psychological, Counseling and Social Work services, including therapy services (only if included in the student's IEP/IFSP/NPSP).
- Orientation and Mobility services and evaluations (only if included in the student's IEP/IFSP/NPSP).
- Nursing services and evaluations (only if included in the student's IEP/IFSP/NPSP), including skilled nursing services on the IEP/IFSP/NPSP and time spent administering/monitoring medication (only if it is included as part of an IEP/IFSP and documented in the IEP/IFSP).

- Physician and Psychiatrist services (only if included in the student's IEP/IFSP/NPSP).
- Assistive Technology Device Services.

4.2.G.3. Personal Care Services

This code is used for providing a range of human assistance services to students with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance or cueing so that the student performs the task by themself. The need for services must be documented in the student's POC. Services are not covered when provided by a family member or if they are educational in nature.

Personal care services include related paperwork, clerical activities, and staff travel required to perform the following activities:

- Eating/feeding
- Respiratory assistance
- Toileting
- Grooming
- Dressing
- Transferring
- Ambulation
- Intervention for seizure disorder
- Personal hygiene
- Mobility/Positioning
- Meal preparation
- Skin care
- Muscle strengthening
- Bathing
- Maintaining continence
- Medical equipment maintenance
- Assistance with self-administered medications
- Re-direction and intervention for behavior
- Health-related functions through hands-on assistance, supervision and cueing

4.2.G.4. Targeted Case Management Services

This code is used for providing services which are a part of the IEP/IFSP/NPSP treatment plan. These services identify and address special health problems and needs that affect

the student's ability to learn and assist the student to gain and coordinate access to a broad range of medically necessary services covered under the Medicaid program.

Targeted Case Management Services include related paperwork, clerical activities, and staff travel required to perform the following activities:

- Ensure that standard re-examination/follow-up of the student is periodically conducted to ensure the student receives needed diagnosis and treatment.
- Assist families in identifying/choosing appropriate care providers and services.
- Maintain case records and indicate all contact for pupil in the same manner as other covered services.
- Coordinate performance evaluations/assessments and other service needs for the pupil.
- Prevention of duplicate services.
- Facilitation/participation in development, review and evaluation of the multi-disciplinary assessment.
- Supporting activities that link or coordinate needed health services for the pupil.
- Meeting with teachers and other professional staff to discuss testing, planning, treatment, coordinating effective interventions, and pupil progress.
- Coordinating school-based services and treatment with parents or guardians and student.
- Monitoring and recommending a plan of action.
- Providing modifications to the multi-disciplinary, pupil-centered treatment plan.
- Coordinating with staff/health professionals to establish continuum of physical and behavioral health services in the school setting.
- Provide summary of provider, parents or guardian and student consultation.

This code also includes pre- and post-time directly related to providing direct student care services when the student is not present. Examples of pre- and post-time activities when the pupil is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-time activities associated with physical therapy services; for example: time to build a customized standing frame for a pupil or time to modify a pupil's wheelchair desk for improved freedom of movement for the pupil.
- Pre- and post-activities associated with speech-language therapy services; for example: preparing lessons for a student to use with an augmentative communicative device (ACD) or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the IEP.
- Travel to the direct service/therapy.

- Paperwork associated with the delivery of the direct care service, as long as the student is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when pupil is not present. (Assessment services are billed for testing time when the pupil is present, for interpretation time when the pupil is not present, and for report writing when the pupil is not present.)

4.2.H. Code 4.c. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service – Medical Plan Ratio

This code should be selected when ISD/LEA staff members (employees or contracted staff) provide direct client services as covered services delivered by ISDs/LEAs under the FFS program when documented on a medical plan other than an IEP/IFSP/NPSP or for services in which medical necessity has been determined. These direct client services may be delivered to a student and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of medical (i.e., health-related) services outlined in a medical plan other than an IEP/IFSP/NPSP or for which medical necessity has been determined. It also includes functions performed pre- and post-actual direct client services (when the pupil may not be present); for example: paperwork, or staff travel directly related to the direct client services.

Examples of activities reported under this code:

4.2.H.1. All Medical Plan Direct Student Services With the Student Present

Includes:

- Providing health/mental health services as covered in the pupil's medical plan other than an IEP/IFSP/NPSP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the pupil's medical plan other than an IEP/IFSP/NPSP.
- Services for which medical necessity has been determined.

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the pupil's medical plan).
- Physical Therapy services and evaluations (only if included in the pupil's medical plan).
- Occupational Therapy services and evaluations (only if included in the pupil's medical plan).
- Speech-Language Therapy services and evaluations (only if included in the pupil's medical plan).

- Counseling services, including therapy services (only if included in the pupil's medical plan or when medical necessity has been determined).
- Orientation and Mobility services and evaluations (only if included in the pupil's medical plan).
- Nursing services and evaluations (only if medical necessity has been determined, including skilled nursing services in the medical plan, and time spent administering/monitoring medication only if it is included as part of a medical plan of care and documented in the medical plan of care).
- Nutrition services, including the management and counseling for pupils on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status and teaching related to the dietary regimen.
- All EPSDT covered services, such as screenings, immunizations, etc., or services in which medical necessity has been determined.

This code also includes pre- and post-time directly related to providing direct client care services when the student is not present. Examples of pre- and post-time activities when the pupil/client is not present include: time to complete all paperwork related to the specific direct client care service such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-time activities associated with physical therapy services; for example: time to build a customized standing frame for a pupil or time to modify a pupil's wheelchair desk for improved freedom of movement for the pupil.
- Pre- and post-activities associated with speech language pathology services; for example: preparing lessons for a client to use with an ACD or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the medical plan of care.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service as long as the pupil/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when pupil/client is not present. (Assessment services are billed for testing time when the pupil is present, for interpretation time when the pupil is not present, and for report writing when the pupil is not present.)

4.2.I. Code 5.a. - Transportation for Non-Medicaid Services – U

This code should be used for staff when assisting a student to obtain transportation to services not covered by Medicaid or accompanying the individual to services not covered by Medicaid. Includes related paperwork, clerical activities and staff travel required to perform these activities:

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

4.2.J. Code 5.b. – Transportation-Related Activities in Support of Medicaid-Covered Services – PM/50 Percent FFP

This code should be used for staff when assisting a student to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct cost of the transportation, but rather the administrative activities involved in providing transportation. Includes related paperwork, clerical activities, and staff travel required to perform these activities. An example is:

- Scheduling or arranging transportation to Medicaid covered services.

NOTE: Staff that may arrange transportation that may be included in the RMTS include, but are not limited to, Program Administrators, Special Education Support or other staff at the district who are responsible for arranging specialized transportation for students to receive medical services; however, job titles of staff that provide these types of services vary by district.

4.2.K. Code 6.a. - Non-Medicaid Translation – U

This code should be used for staff when providing translation services related to social, vocational or educational programs and activities as an activity separate from the activities referenced in other codes. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral or signing services) that assist the student to access and understand social, educational, and vocational services.
- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand State education or State-mandated health screenings (e.g., vision, hearing, and scoliosis) and general health education outreach campaigns intended for the student population.
- Developing translation materials that assist students to access and understand social, educational, and vocational services.

4.2.L. Code 6.b. - Translation Related to Medicaid Services - PM/75 Percent FFP

Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units

or separate staff members performing solely translation functions for the ISD/LEA and it must facilitate access to Medicaid covered services.

This code should be used by ISD/LEA employees who provide translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. This includes related paperwork, clerical activities and staff member travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral and signing) that assist the student to access and understand necessary care or treatment covered by Medicaid.
- Developing translation materials that assist the student to access and understand necessary care or treatment covered by Medicaid.
- Developing translated materials, including Braille transcriptions, that assist the student to access and understand necessary care or treatment covered by Medicaid.
- Translation while the school nurse provides covered services to a student whose primary language is not English.
- Sign language interpretation during provision of covered services to a deaf/hearing impaired student.
- Transcribing into Braille the fact sheet that school nurses use to explain/practice steps/proper technique for using an inhaler.
- Translation to help a school psychologist follow up with a student's non-English speaking parent or guardian on a mental health referral.

4.2.M. Code 7.a. - Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services – U

This code should be used for staff when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services to school age pupils and when performing collaborative activities with other agencies. Non-medical services may include social, educational and vocational services. Only staff members whose position descriptions include program planning, policy development and interagency coordination should use this code. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Identifying gaps in or duplication of non-medical services (e.g., social, vocational, educational and state-mandated general health care programs) to school age pupils and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.
- Developing procedures for tracking parent or guardian requests for assistance with non-medical services and the providers of such services.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.

- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the relationship of each agency's non-medical services to one another.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the schools.

4.2.N. Code 7.b. - Program Planning, Policy Development and Interagency Coordination Related to Medical/Medicaid Services - PM/50 Percent FFP

This code should be used for staff members when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age pupils, and when performing collaborative activities with other agencies and/or providers. Staff members whose position descriptions include program planning, policy development and interagency coordination may use this code. However, it is a state option whether or not the position descriptions need to be explicit with respect to these specific functions. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services. This includes related paperwork, clerical activities and staff member travel required to perform these activities. Examples include:

- Identifying gaps in or duplication of medical/dental/mental health services to school age pupils and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking parent or guardian requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible, and to increase provider participation and improve provider relations.

- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Defining the relationship of each agency's Medicaid services to one another.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Developing medical referral sources, such as directories of Medicaid providers and managed care plans, which will provide services to targeted population groups, e.g., EPSDT pupils.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

4.2.O. Code 8.a. - Non-Medical/Medicaid Training – U

This code should be used for staff coordinating, conducting, or participating in training events and seminars for school-based services staff regarding the benefit of the programs, other than the Medicaid program, such as educational programs; for example: how to assist parents or guardians to access the services of the relevant programs and how to refer pupils more effectively for those services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA child find programs.

4.2.P. Code 8.b. - Medical/Medicaid Related Training – PM/50 Percent FFP

This code should be used for staff when coordinating, conducting or participating in training events and seminars for Direct Medical Services and AOP staff regarding the benefits of the Medicaid program, how to assist parents or guardians in accessing Medicaid services, and how to more effectively refer pupils for services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
- Participating in or coordinating training that enhances early identification, intervention, and screening of pupils with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)

4.2.Q. Code 9.a. - Referral, Coordination and Monitoring of Non-Medicaid Services –U

This code should be used for staff when making referrals for coordinating and/or monitoring the delivery of non-medical, such as educational, services. Includes related paperwork, clerical activities and staff travel required to perform these activities. Examples include:

- Making referrals for, and coordinating access to, social and educational services such as childcare, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, and scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a pupil's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the plan of care as appropriate.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost. This code should be used for school staff when making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.R. Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services – PM/50 Percent FFP

This code should be used for staff when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP/IFSP/NPSP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of, or an extension of, a medical service (e.g., student follow-up, student assessment, student counseling, student education, student consultation, billing activities) should be reported under codes 4.a. - Direct Medical Services - Not Covered on a Medical Plan of Care (FFS – Non-IEP); 4.b. - Direct Medical Services - Covered as IDEA/IEP Services (FFS – IEP); or 4.c. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service. Examples include:

- Identifying and referring pupils who may be in need of Medicaid family planning services.

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
- Referring pupils for necessary physical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a pupil's needs for health-related services covered by Medicaid.
- Developing, coordinating, and monitoring the medical portion of the IEP for a pupil which includes the medical portion of the actual IEP meetings with the parents or guardians, time spent developing the medical services plan on the IEP, and writing of the medical service goals of the IEP. (If appropriate, this would also refer to the same activities performed in support of an IFSP or other medical plan.)
- Providing follow-up contact to ensure that a pupil has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a pupil with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the pupil to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the pupil's related medical/dental/mental health services and plans.
- Monitoring and evaluating the Medicaid service components of the IEP and/or medical plan as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

NOTE: A "referral" is considered appropriate when made to a provider who can provide the required service, will accept the pupil as a patient, and will accept the pupil's source of payment for services.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost. This code should be used for school staff members when

making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.S. Code 10. - General Administration – R

This code should be used for staff when performing activities that are not directly assignable to program activities. Includes related paperwork, clerical activities and staff travel required to perform these activities. Note that certain functions such as payroll, maintaining inventories, developing budgets, executive direction, etc. are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities; however, they are not all inclusive.

- Taking lunch, breaks, leave, or other paid time not at work.
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school procedures and rules.
- Attending or facilitating school staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff members, including supervision of student teachers or classroom volunteers, and evaluation of staff member performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

4.2.T. Code 11. - Not Scheduled to Work – Not Included in the Distribution or Invalid

This code should be used if the random moment occurs at a time when a part-time, temporary or contracted employee is not scheduled to be at work. NOTE: This code should not be used for full-time school staff.

SECTION 5 – CONFIDENTIALITY

Aggregate time study data may occasionally be useful for other administrative tasks (i.e., planning) and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy. Aggregate data is defined as data at the state level. That data may be broken down by cost pool as well.

SECTION 6 – TIME STUDY TRAINING

6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies.

The Contractor, along with MDHHS, is responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide and other services that will be provided to the individual ISDs.

6.1.A. LOCAL ISD COORDINATOR TRAINING

All ISDs have an ISD coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study and cost reporting activities. These individuals must understand their role as the liaison between the Medicaid Program, the Contractor, and other staff. They must understand and be able to convey to others the basic purpose of the program, assist the Contractor with follow-up as needed, and serve as a facilitator for the Contractor to "navigate" the district as necessary.

6.1.B. TIME STUDY PARTICIPANT TRAINING

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form, and that their role is crucial to the success of the time study. The Contractor develops and provides detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet provides a "tutorial" with the aforementioned basics of the program as well as information about the Medicaid covered services provided in the school setting.

SECTION 7 – SUMMARY OF TIME STUDY STEPS

The Contractor duties are to:

- Import eligible school district staff information to create the RMTS staff pools.
- Randomly select staff/moments to be sampled.
- Generate electronic RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD Coordinators as a local control list.
- Code the time study responses.
- Calculate activity percentages for each of the activity codes.
- Scan completed and coded time study moments.
- Transfer raw data from submitted RMTS responses to the claims development software to calculate activity percentages for each of the activity codes.
- Produce quarterly reports summarizing the results of the RMTS and RMTS compliance reporting. (Both reports are forwarded to the MDHHS Program Policy Division for posting on the MDHHS website. Refer to the Directory Appendix for website information.)
- Produce periodic and special RMTS reports that provide data and information sorted by ISD/LEA that are provided to CMS, MDHHS, MDE, ISDs and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs.
- Distribute time study moments and collect completed time study moments.
- Code the activity forms received from the ISDs.
- Initiate and complete the ISD claim workbooks by obtaining the financial data from each ISD/LEA and compiling data to complete the workbook.

SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

8.1 AOP QUARTERLY CLAIM (OTHER THAN SUMMER QUARTER)

The claim consists of the results of the quarterly RMTS of the approved staff pool for the quarter and the correlating allowable costs applied to the reimbursement methodology.

8.2 AOP SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff. Currently, a time study is not conducted during the July – September period.

8.2.A. JULY - SEPTEMBER CLAIM

The summer quarter is comprised of the following elements:

- Staff Pool – those eligible staff in the April through June staff pool define the positions for which costs can be claimed during the summer period.
- Costs – July - September allowable staff pool costs
- A weighted average of the October-December, January-March, April-June, and the summertime study results.

8.3 DIRECT MEDICAL SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

A weighted average of the three time study results for the staff pool periods listed below is applied to the LEA Cost Report total costs. The LEA Cost Report costs include the annual costs associated with direct medical services, personal care services and targeted case management services.

The direct medical services time study application is comprised of the following elements:

- Staff Pools – Those individuals eligible to participate in the following three staff pool periods:
  - October through December
  - January through March
  - April through June
- Cost Pool – The costs from the annual LEA Cost Report (direct medical services, personal care services and targeted case management services).
- RMTS – A weighted average of the October–December, January–March, April–June and the summertime study results as described above.

8.4 Financial Reporting Compliance Requirements

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from ISD/LEA payroll and financial systems. Payroll and financial systems data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.

SECTION 9 – AUDIT AND QUALITY ASSURANCE

9.1 STATEMENT ON STANDARDS FOR ATTESTATION ENGAGEMENTS (SSAE) 18 AUDIT REQUIREMENTS

In accordance with the *State of Michigan Financial Management Guide (FMG) Part VII: Internal Control, Chapter 1, Section 1000: Managing and Evaluating Controls for Third Party Risks*, the state contractor must annually provide the State, at the state contractor's expense, a Service Organization Control (SOC) 2 Type II report performed by an independent auditor in accordance with standards (currently SSAE18) issued by the American Institute of Certified Public Accountants (AICPA). The SOC 2 provides reporting on internal controls at a service organization relevant to security, availability, processing integrity, confidentiality, and privacy. The state contractor must also provide the State annually a SOC 1 Type II report performed by an independent auditor using the same applicable standards.

Within 60 days of the SOC report issue date, the Contractor must submit the SOC report along with a "Bridge" letter covering the "gap" between the Contractor's SOC report period and the State's fiscal year: 9/30/yy. The "Bridge" letter must assert that the control environment described in the SOC report has not changed and that tested controls continued to operate effectively during gaps between the SOC reporting period and the State of Michigan's fiscal year.

9.2 QUALITY ASSURANCE, OVERSIGHT AND MONITORING

Quality assurance, oversight and monitoring activities include:

9.2.A. MDHHS PROGRAM POLICY – OVERSIGHT OF ADMINISTRATION AND OPERATIONS

MDHHS policy staff responsibilities are:

- Review quarterly time study results against historical benchmarks according to:
  - Overall results and matchable percentages
  - Benchmarks by activity code and by staff category
- Detailed investigation of anomalies in results.
- Determination of policy or procedure changes based on results of anomaly review.
- Overall statistical requirements in terms of confidence and precision levels on a quarterly basis and an annual basis.
- Sampling to review coding activities performed by the Contractor.
- Disseminate CMS guidance.
- Monitor ISDs processing of claims for compliance with State and Federal regulations and program guidelines.
- Ensure that billing entities have the processes in place to correct any claims paid in error.
- Provide information and training to billing entities as needed for program compliance.
- Provide operational oversight and technical assistance.
- Assist ISDs with quality assurance and compliance monitoring.

- Provide oversight of ISD quality assurance and compliance plans to ensure that they provide oversight and monitoring of such things as documentation, provider credentials, record retention, and confidentiality.

9.2.B. MDHHS Office of Inspector General – Post-Payment Review and Compliance

MDHHS Office of Inspector General staff responsibilities are:

- Post-payment review for the purpose of adherence to provider policy, provider credentials and appropriate billing practices.
- Post-payment review for the purpose of reported fraud or abuse.

For more detailed information regarding the Fraud and Abuse and Post Payment Review, refer to the Post-Payment Review and Fraud/Abuse section of the General Information for Providers chapter.

9.2.C. MDHHS Rate Review Section – Cost Settlement Review

MDHHS Rate Review Section staff responsibilities are:

- Import and create a database of the cost report data submitted by ISDs.
- Perform reviews of the data for accuracy and completeness.
- Summarize the data and forward to ISDs for final approval.
- Compile cost settlement summaries and prepare over/under adjustments.

9.2.D. Contractor Oversight and Quality Assurance

There are several levels of quality assurance and validation built into the RMTS process.

- In terms of coding, the Contractor has a coding process in place in which centralized coders code all moments, and then a second coder reviews all moments coded as matchable for verification of accurate and consistent application of activity codes. The second coder also reviews a random sample of 10 percent of all non-matchable moments for quality assurance purposes.
- Quality assurance and validation includes the quarterly review which includes the Contractor meeting with MDHHS staff specifically to review time study results and other procedural issues. Each quarter, MDHHS reviews detailed reports which outline the current quarter time study results benchmarked against past quarter results. The results are reviewed by activity code as well as by matchable/non-matchable categories. Comparisons are made of the variances in the overall quarterly results from the same quarter in the previous year, as well as variances of the current quarter against the average of the past four quarters. Results are reviewed and discussed in terms of results by staff category. Any anomalies identified are pursued through a detailed investigation of the moments which produced the anomaly. The Contractor, in conjunction with MDHHS, then determines how to handle any issues in terms of additional communication or training for RMTS participants, policy or procedural changes, etc.

- ISDs may view compliance reporting online.

9.2.E. ISD Oversight

ISD responsibilities are to:

- have systems in place to monitor service delivery, claim documentation, claim billing, and payments received.
- verify that the credentials of all clinicians are current and appropriate for Medicaid billing and that services rendered are within the scope of the clinician's practice.

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Michigan Department of Health and Human Services (MDHHS) administers the Medicaid Program, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS) and other special programs described elsewhere in this manual. In addition to these traditional programs, MDHHS administers many other programs/coverages to meet the healthcare needs of Michigan's medically indigent population. Programs vary in scope and eligibility requirements and are funded through various sources, including federal, state, and/or private. Some of the programs offer comprehensive or reduced Medicaid benefits as indicated. Additional information regarding these programs may be available on the MDHHS website.

Contact information for the various programs is listed in the Directory Appendix.

SECTION 2 – PROGRAMS THAT TARGET SPECIFIC MEDICAL CONDITIONS

2.1 BREAST AND CERVICAL CANCER CONTROL PROGRAM

2.1.A. ELIGIBLE BENEFICIARIES

The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages especially, but not limited to, women aged 40-64. Certain income restrictions do apply. Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays.

- Insured women may apply if certain insurance, age, and income requirements are met.
- Women who are enrolled in a managed care program, health maintenance organization (HMO) or have Medicare Part B are not eligible.

2.1.B. COVERED SERVICES

Covered services include:

- Clinical breast exams
- Pap smears
- Pelvic exams
- Screening mammogram, and
- Appropriate referral to community providers for follow-up of abnormalities.

Breast biopsy, colposcopy-directed services, colposcopy service, diagnostic mammograms, and loop electrosurgical excision procedure (LEEP) may be provided based upon medical needs, financial and insurance status, and availability of federal grant funds or Michigan tobacco tax dollars.

SECTION 3 – GENERAL COVERAGE PROGRAMS

3.1 FREEDOM TO WORK

3.1.A. ELIGIBLE BENEFICIARIES

Medicaid-eligible disabled adults aged 16 through 64 years old with earned income may be eligible. SSI beneficiaries whose SSI eligibility may end due to financial factors are among those eligible to be considered for this program.

To be eligible, the beneficiary must be employed on a regular and continuing basis. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary.

For a married beneficiary, the spouse's income and assets are not considered when determining eligibility for this Medicaid category. The beneficiary's total countable unearned income cannot exceed 250 percent of the Federal Poverty Level (FPL) for ongoing eligibility. The beneficiary's countable assets are limited to $75,000. In addition, the beneficiary is allowed to have IRS-recognized retirement accounts (including IRAs and 401Ks) of unlimited value.

3.1.B. COVERED SERVICES

Freedom To Work beneficiaries receive regular Medicaid coverage.

3.1.C. PREMIUMS

If the beneficiary's Modified Adjusted Gross Income (MAGI) is below 138 percent of the FPL, there is no premium required for coverage. If the beneficiary's MAGI is between 138 percent of the FPL and $75,000 per year, the premium is 2.5 percent of MAGI. If the total countable earned income exceeds $75,000 per year, the beneficiary must pay a premium equal to 100 percent of the cost of Medicaid coverage.

3.2 MEDICAID FOR SUPPLEMENTAL SECURITY INCOME BENEFICIARIES

3.2.A. ELIGIBLE BENEFICIARIES

Supplemental Security Income (SSI) covers disabled children whose families have low income, and low-income adults who are aged, disabled or blind. The Social Security Administration determines eligibility and awards monthly SSI payments based on income and assets requirements. Beneficiaries awarded SSI are automatically eligible for regular Medicaid coverage.

3.2.B. COVERED SERVICES

SSI beneficiaries are eligible for regular Medicaid. In some cases, Medicare premiums are paid by Medicaid based upon certain individual situations and previous work histories.

3.3 Medicare Savings Program

3.3.A. Eligible Beneficiaries

Low income Medicare beneficiaries and those individuals who are eligible for Medicare but do not enroll due to the cost may participate in the Medicare Savings Program (MSP). Financial and nonfinancial requirements and restrictions do apply.

3.3.B. Covered Services

The MSP pays Medicare coinsurance, deductible, and premiums.

3.4 Special N Support

3.4.A. Eligible Beneficiaries

Families that received the low-income families (LIF) Medicaid but are no longer eligible due to an increase in child support may qualify for Special N Support. Most of the health coverage is provided by Medicaid Health Plans (MHPs), and the majority of the beneficiaries are already enrolled in a MHP.

3.4.B. Covered Services

Special N Support beneficiaries receive regular Medicaid coverage for four months.

3.5 Transitional Medical Assistance

3.5.A. Eligible Beneficiaries

Transitional Medical Assistance (TMA) covers families who are U.S. citizens that are no longer eligible for the low-income family (LIF) Medicaid because the parent(s) has too much income from employment. The family must have received low-income family Medicaid for at least three months of the previous six months to be eligible for TMA. Most of the health coverage is provided by HMOs contracted by MDHHS. The majority of the beneficiaries are already enrolled in a MHP. A renewal of the application to TMA is not necessary.

3.5.B. Covered Services

TMA provides regular Medicaid coverage, or a comprehensive health care package that includes vision, dental and mental health services, if the beneficiary has been enrolled in a MHP for 12 months.

SECTION 4 – CHILD AND ADOLESCENT HEALTH CENTERS AND PROGRAMS

Under an agreement with MDHHS, Child and Adolescent Health Centers and Programs (CAHCPs) provide medical services and outreach on behalf of the Medicaid Health Plans (MHPs) to school-aged children. (Refer to the Medicaid Health Plan Chapter of this manual for additional information.)

SECTION 5 – COMMUNITY-BASED LONG TERM CARE

5.1 MI CHOICE WAIVER (HOME AND COMMUNITY-BASED WAIVER FOR THE ELDERLY AND DISABLED)

The MI Choice Waiver provides services to aged and physically disabled individuals 18 years old and over who are eligible for full Medicaid and want to stay in their homes or another residential setting but, without the provision of waiver services, would require the level of care only available in a nursing facility. Income and assets requirements and restrictions apply. Applicants must also meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria. Individuals must be currently Medicaid approved or be Medicaid eligible if they were to enter a nursing facility. MDHHS contracts with local agencies to administer this program. (Refer to the MI Choice Waiver Chapter for additional information.)

5.2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system for frail, elderly individuals who meet the Michigan Medicaid Nursing Facility Level of Care criteria. Refer to the PACE Chapter of this manual for additional information.

SECTION 6 - FLINT FAMILY SUPPORTS COORDINATION SERVICES

Family Supports Coordination services are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system who meet the Medicaid eligibility requirements.

Family Supports Coordination services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. Family Supports Coordination services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities.

In addition to Family Supports Coordination services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children up to age 21, Non-Emergency Medical Transportation (NEMT), and Maternal Infant Health Program (MIHP) services.

6.1 ELIGIBILITY

Providers may verify beneficiary eligibility for Family Supports Coordination services through a Community Health Automated Medicaid Processing System (CHAMPS) online eligibility inquiry or via a Health Insurance Portability and Accountability Act (HIPAA) 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for Family Supports Coordination services will show:

- a current MAGI category beginning with "F"; and
- a current benefit plan of "TCMF" in addition to their assigned Medicaid or Children's Health Insurance Program (CHIP)-related benefit plans.

6.2 CORE ELEMENTS OF FAMILY SUPPORTS COORDINATION

The purpose of Family Supports Coordination services is to provide a comprehensive array of services that are appropriate to the conditions of the individual. At a minimum, Family Supports Coordination services must include:

- a comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care;
- planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;
- coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid Health Plan (MHP), as applicable; and
- any other service approved by MDHHS.

6.2.A. INITIAL/ ANNUAL COMPREHENSIVE ASSESSMENT VISIT

All comprehensive assessment visits, including the initial in-person comprehensive assessment visit, must be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an

individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening. Initial comprehensive assessments must be conducted in person while re-assessments may be conducted face-to-face.

It is expected that face-to-face re-assessments are performed annually; however, the frequency should be based on the needs and circumstances of the beneficiary and/or family. Active participation by the beneficiary and/or parent(s)/legal guardian(s) is necessary. Comprehensive assessment activities include:

- obtaining client history;
- identifying the beneficiary's needs and completing related documentation; and
- gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the beneficiary.

At a minimum, the comprehensive assessment visit shall assess:

- the growth and development of beneficiaries up to age 21;
- the behavioral profile of beneficiaries up to the age of 21, including the notation of aggressive or hyperactive behavior;
- the beneficiary's access to a PCP and other health care providers;
- whether the beneficiary's PCP has conducted a developmental and social-emotional screen(s) utilizing a standardized and validated tool, such as the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) or the Pediatric Symptom Checklist (PSC) as indicated by the American Academy of Pediatrics (AAP) Periodicity Schedule, and documenting the results of any screenings performed;
- whether the beneficiary's PCP has assessed the beneficiary for sources of toxic stress and for sources of strength using nationally recognized tools, such as the Adverse Childhood Experiences (ACEs) and Resiliency questionnaires, and documenting the results of any screenings performed;
- the beneficiary's access to prenatal care, potential for pregnancy complications, pica activities, and intent to breastfeed (pregnant beneficiaries);
- the beneficiary's educational and nutritional needs, including participation in the Women, Infants and Children (WIC) program and/or the Food Assistance Program (FAP);
- the beneficiary's environment and typical family practices that may pose a lead risk;
- lead hazards within the family's dwelling; and
- access to NEMT.

6.2.B. Development of the Plan of Care and Documentation

During or immediately following the initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in Family Supports Coordination services, with the active participation of the parent(s)/legal guardian(s)

when applicable. The development (and periodic revision) of a specific Plan of Care that is based on the information collected through the comprehensive assessment must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The supports coordinator must ensure the active participation of the beneficiary, and work with the beneficiary (or the beneficiary's parent[s]/legal guardian[s]) and others to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The Plan of Care is to be shared with the beneficiary's MHP and PCP, if applicable. Beneficiaries must consent to share the Plan of Care with the MHP and other providers identified in the Plan of Care. At a minimum, the Plan of Care must:

- identify a course of action to respond to the assessed needs of the beneficiary (e.g., plan for the testing of family members at risk for lead hazard exposure);
- provide education and information regarding lead hazards, including the impact of lead exposure on the developing fetus of pregnant beneficiaries; and
- facilitate blood lead testing and follow-up testing and treatment as recommended by the PCP.

Family Supports Coordination providers are required to document the following information for all beneficiaries receiving Family Supports Coordination services:

- the name of the beneficiary;
- the dates of the supports coordination services;
- the name of the Family Supports Coordination provider and the qualified professional (i.e., licensed nurse or social worker) providing the supports coordination services;
- the nature and content of the supports coordination visits received, and whether goals specified in the Plan of Care have been achieved;
- whether the beneficiary has declined services within the Plan of Care;
- the need for, and occurrences of, coordination with other providers;
- a timeline for obtaining needed services;
- a timeline for re-evaluation of the Plan of Care; and
- the beneficiary's consent to share information.

6.2.C. Referrals and Related Activities

In collaboration with the PCP and the MHP, it is expected that the supports coordinator will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other programs and services to address identified needs and achieve goals specified in the Plan of Care are primary components of Family Supports Coordination services. Referral activities include, but are not limited to, the coordination of age-appropriate services such as:

- health care related services, including physical and specialty behavioral health services;

- nutritional services, such as coordinating referrals to the Special Supplemental Nutrition Program, WIC program, or FAP;
- educational services, such as age-appropriate referrals to Early On, Great Start Readiness Programs, and Head Start;
- additional social supports (including home visiting programs) to assist the beneficiary in obtaining other assistance, such as financial, housing, and transportation assistance, and lead assessment and abatement resources; and
- blood lead testing and re-testing for family members at risk for lead exposure, and education regarding lead hazards including the impact of lead exposure on young children and the developing fetus.

6.2.D. Monitoring and Follow-Up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the Plan of Care is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted as frequently as necessary by the supports coordinator.

A maximum of five (5) face-to-face monitoring visits are billable per year for each eligible beneficiary. To be reimbursed, the visit must be face-to-face. Additional monitoring and follow-up activities are likely between face-to-face visits but are not reimbursable. At least one annual face-to-face monitoring visit should be conducted to determine whether the following conditions are met:

- services are being furnished in accordance with the beneficiary's Plan of Care;
- services in the Plan of Care are adequate; and
- changes in the needs or status of the beneficiary are reflected in the Plan of Care.

Monitoring and follow-up activities include making necessary adjustments in the Plan of Care and service arrangements with providers.

6.3 Accessing Services

Accessing Family Supports Coordination services may occur a number of ways. If the beneficiary is an MHP member, the MHP may initiate the initial contact with the beneficiary and identify those beneficiaries that may benefit from Family Supports Coordination services. Fee-for-Service (FFS) and MHP beneficiaries may also access Family Supports Coordination services either through a referral from their PCP or through a self-referral.

6.4 Covered Supports and Services

A maximum of six (6) visits per year will be reimbursed for each eligible beneficiary as follows:

- one (1) visit for the initial/annual comprehensive assessment.
- a maximum of five (5) visits for monitoring and follow-up.

For additional visits, MDHHS requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix for contact information regarding prior authorizations.)

Reimbursement for assessment and monitoring visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit.

Medicaid reimbursement for Family Supports Coordination services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Supports coordination includes contacts with non-eligible beneficiaries when the contact is:

- directly related to identifying the eligible beneficiary's needs and care for the purpose of assisting the beneficiary in accessing services;
- identifying needs and supports to assist the beneficiary in obtaining services;
- providing supports coordinators with useful feedback; and
- alerting supports coordinators to changes in the beneficiary's needs.

Family supports coordination does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred, including foster care programs and services such as, but not limited to, the following:

- research gathering and completion of documentation required by the foster care program;
- assessing adoption placements;
- recruiting or interviewing potential foster care parents;
- serving legal papers;
- home investigations;
- providing transportation;
- administering foster care subsidies; and
- making placement arrangements.

6.5 Transfer of Care/Records

During the course of care, the beneficiary may require services from a different supports coordinator due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change supports coordinators. When there is a planned change of the supports coordinator, information about the new supports coordinator (e.g., contact information) should be provided to the beneficiary. The referring supports coordinator must consult with the new supports coordinator about the case and transfer all applicable information and records, including all completed assessment visits and the updated Plan of Care, to the new supports coordinator in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the HIPAA and the Michigan Mental Health Code.

6.6 Family Supports Coordination Closure

Family Supports Coordination services are available to all eligible beneficiaries up to age 21, or for pregnant women up to and through 12 months post-delivery. Family Supports Coordination services will be discontinued:

- if the beneficiary is no longer eligible;
- when the beneficiary parent(s) or guardian(s) refuses the service; or
- if CMS does not extend the Flint, Michigan Section 1115 Demonstration Waiver.

When services are refused, Family Supports Coordination services may be resumed at any point during the defined period of eligibility. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and provided to the PCP when the Family Supports Coordination case is closed.

6.7 Provider Qualifications

Genesee Health System, the local community mental health (CMH) serving Genesee County, serves as the Designated Provider Organization (DPO) for Family Supports Coordination services. The DPO:

- has a sufficient number of qualified staff to meet the service needs of the target population and has the administrative capacity to ensure the provision of quality services in accordance with state and federal requirements;
- has experience in the coordination and linkage of community services;
- has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable; and
- must seek approval by MDHHS of all subcontractors for the provision of Family Supports Coordination services.

The DPO will provide Family Supports Coordination services primarily through the use of a supports coordinator. The supports coordinator must meet one of the following professional qualifications:

- licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA), and at least one year of experience providing community health, pediatric or maternal infant health nursing services; or
- licensure as a social worker by LARA, and at least one year of experience providing social work services to families.

6.8 Claims Submission and Payment

All claims submitted and accepted are processed through CHAMPS. Claims must be submitted on the ASC X12N 837 5010 professional format when submitting electronic claims or on the CMS 1500 claim form for paper claims. (Refer to the Billing & Reimbursement for Professionals Chapter for additional billing information.)

6.8.A. Initial/Annual Assessments

Assessment visits are to be billed using HCPCS code T2024 for an individual or family. This includes reimbursement for the development of a Plan of Care for one individual. HCPCS code T2024 with modifier TT (additional patient) should be billed for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served).

Assessment visits must be in the home or "home-like" environment. One initial/annual assessment visit per year per family/household is allowed. Additional assessment visits beyond one per year per family/household require prior authorization.

6.8.B. Follow-up/Monitoring

Face-to-face follow-up/monitoring visits are to be billed using HCPCS code T1017 for an individual or family. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served), and enter the Medicaid beneficiary ID numbers of the family members served during the follow-up visit in the claim notes.

Follow-up visits must last at least 30 minutes and ideally take place in the home or "home-like" environment but may be performed in the office. A maximum of five face-to face follow-up/monitoring visits per year per family/household is allowed. Additional follow-up visits beyond five per year per beneficiary require prior authorization.

SECTION 7 – MICHIGAN DIABETES PREVENTION PROGRAM (MIDPP)

Michigan Diabetes Prevention Program (MiDPP) is an evidence-based program based on the Centers for Disease Control and Prevention Diabetes Prevention Program (CDC DPP). It is a unique Medicaid preventive benefit that provides a formal behavioral modification approach to preventing type 2 diabetes.

Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs) must provide the MiDPP benefit and may provide services over and above the FFS program. For beneficiaries enrolled in an MHP or ICO, MiDPP providers should check with the beneficiary's health plan for prior authorization or referral requirements.

7.1 GENERAL INFORMATION

Prediabetes is a precursor to type 2 diabetes. Type 2 diabetes predisposes people to additional health problems, such as heart disease, kidney disease, vision loss, and amputation.

MiDPP is a unique Medicaid preventive benefit that provides a formal behavioral modification approach to preventing type 2 diabetes. To support the MDHHS commitment to reducing health disparities for Michigan Medicaid beneficiaries, MiDPP is available in a variety of languages and tailored to meet the cultural needs of participants through a variety of delivery modes. In addition, beneficiaries receive support through interactions with others with similar goals and challenges.

The CDC curriculum for MiDPP uses healthy eating, physical activity, and behavior modifications for stress management and problem-solving. Participants learn healthy behaviors, set goals for weight loss, and are encouraged to work up to 150 minutes of physical activity per week.

7.2 MIDPP COVERED SERVICES

The MiDPP structured one-hour sessions for health behavior change are provided by a Medicaid-enrolled lifestyle coach associated with an enrolled MiDPP provider. As required by federal regulations in CFR 440.130(c), MiDPP for a qualified beneficiary must be recommended by a licensed healthcare provider. Examples of healthcare providers qualified to recommend MiDPP are those licensed in Michigan such as a practical nurse, registered nurse, midwife, pharmacist, social worker, physician assistant or physician. Documentation of the MiDPP recommendation must be noted in the beneficiary's program record.

7.3 BENEFICIARY ELIGIBILITY

Medicaid covers MiDPP for beneficiaries who meet the following criteria:

- Current Medicaid eligibility and aged 18 years or over
- Overweight or obese as defined by Body Mass Index (BMI) and have one of the following:
  - elevated blood glucose levels according to CDC Diabetes Prevention Recognition Program (DPRP) Standards and Operating Procedures;
  - history of gestational diabetes mellitus (GDM); or
  - score at "high risk" on CDC prediabetes risk test.

A beneficiary with previously diagnosed type 1 or type 2 diabetes or who is currently pregnant is not eligible to enroll in MiDPP. The beneficiary should be referred to their healthcare provider and is eligible for Medicaid Diabetes Self-Management Education Services (DSME). (Refer to the Billing & Reimbursement for Institutional Providers chapter, Diabetes Self-Management Education (DSME) Training Program subsection, for information on the DSME benefit.) A beneficiary whose prediabetes diagnosis changes to diabetes during a MiDPP session may continue upon recommendation of their healthcare provider. A beneficiary may repeat the MiDPP as long as they meet the eligibility guidelines identified above.

7.4 MiDPP Provider and Lifestyle Coach

A MiDPP provider is the organizational and billing entity, and the MiDPP lifestyle coach is the session leader and rendering provider. Each must meet CDC recognition standards, including educational and experience requirements, as well as meet MDHHS provider enrollment requirements. It is the responsibility of the enrolled MiDPP provider to ensure the lifestyle coaches affiliated with their programs meet CDC program requirements and are enrolled in Medicaid.

The Diabetes & Kidney Unit (DKU) within the MDHHS Public Health Administration (PHA) will monitor MiDPP providers and lifestyle coaches for compliance to CDC recognition requirements. This includes provider qualifications, required training, and necessary data collection. Information regarding the approval process to become a MiDPP provider is available through the DKU. (Refer to the Directory Appendix for contact information.)

Once the MiDPP provider, including lifestyle coaches, are approved by the DKU, enrollment may be initiated in the Michigan Medicaid Community Health Automated Medicaid Processing System (CHAMPS). An enrolling MiDPP provider must have a Type 2 (Organization) National Provider Identification (NPI) number and the lifestyle coach must have a Type 1 (Individual) NPI number before enrolling in CHAMPS. (Refer to the Directory Appendix for CHAMPS Provider Enrollment website information.)

MiDPP providers and lifestyle coaches are subject to all relevant policy found in the General Information for Providers chapter in this manual.

7.5 Billing and Reimbursement

MiDPP claims are submitted only by the Medicaid enrolled MiDPP provider. Claims are submitted on a professional claim format and must include an approved MiDPP Healthcare Common Procedure Coding System (HCPCS) code and must include the diagnosis code of Z71.89: Other Specified Counseling. Weight loss that meets a coding requirement for reimbursement must be documented on the MiDPP beneficiary's program record.

Currently covered MiDPP procedure codes, rates and code descriptions are maintained on the MiDPP fee schedule located on the MDHHS website. (Refer to the Directory Appendix for website information.)

Medicaid will follow CMS Medicare coding and reimbursement guidelines as closely as possible. Providers with questions or needing assistance with MiDPP billing should contact the MDHHS PHA Diabetes & Kidney Unit. (Refer to the Directory Appendix for contact information.)

7.5.A. Other Billing Considerations [Change Made 4/1/2025]

The enrolled provider's lifestyle coach engages with the MiDPP beneficiary to determine the best learning situation for the individual and their ability to access sessions.

Sessions may take place in the following modalities and make-up sessions are encouraged:

- In-person.
- Distance Learning (synchronous audio-visual or audio-only telemedicine): Lifestyle coaches deliver sessions where the coach is present in one location and participants are participating from another location.
- Online: An asynchronous mode of delivery where participants log into course sessions via a computer, tablet, or smart phone. Per CDC requirements and Medicaid policy, MiDPP lifestyle coach interaction (in person or via synchronous telemedicine) is required and must be no less than once per week during the first six months and once per month during the second six months.

When billing for a telemedicine session, synchronous or asynchronous, MiDPP providers are expected to adhere to current MDHHS telemedicine policy **(revised 4/1/2025)** as found in the Telemedicine Chapter of this manual. Refer to the Michigan Medicaid Telemedicine Fee Schedule for the list of current codes acceptable for MiDPP telemedicine claims. (Refer to the Directory Appendix for fee schedule website information.)

Claims for an asynchronous session must include the appropriate procedure code and the remark "Service provided via an asynchronous telemedicine platform".

7.6 Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Tribal Health Center (THC) and Tribal FQHC Reimbursement

MiDPP services are reimbursed at the Medicaid Fee Screen reimbursement rate and are not eligible for the Prospective Payment System (PPS) or the All-Inclusive Rate (AIR). Claims for sessions are submitted on the professional claim form with NPI numbers specific to the clinic MiDPP provider and lifestyle coaches.

7.7 Program Oversight

The DKU and the Michigan Medicaid policy area will monitor the MiDPP through quality checks of documentation and required data reporting. CDC recognition status and delivery mode capabilities of each MiDPP provider and associated lifestyle coaches will be tracked to ensure continued Medicaid provider enrollment eligibility.

MiDPP records will be used to verify that a Medicaid beneficiary has met requirements for billed MiDPP codes. Documentation for review must be available. For information on Medicaid post-payment review, refer to the General Information for Providers chapter of this Manual, Post-Payment Review and Fraud/Abuse section.

SECTION 8 – MICHILD

8.1 ELIGIBLE BENEFICIARIES

The MIChild Medicaid program provides health care coverage for children who:

- Are age 0 through 18
- Have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income (MAGI) methodology
- Do not have other comprehensive medical insurance (this includes insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy and physician services)
- Do not qualify for other MAGI related Medicaid programs
- Are residents of the State of Michigan

The child's eligibility for MIChild is determined through the MAGI methodology. All criteria for MAGI eligibility must be met to be eligible for MIChild.

Children enrolled in MIChild are exempt from copay for services.

8.2 COVERED SERVICES

Children enrolled in MIChild are considered Medicaid beneficiaries and are entitled to all Medicaid covered services.

SECTION 9 – PEDIATRIC OUTPATIENT INTENSIVE FEEDING PROGRAM SERVICES

Pediatric Outpatient Intensive Feeding Program services are for beneficiaries with significant feeding and swallowing difficulties and are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.)

Pediatric Outpatient Intensive Feeding Program services may be reimbursed through Medicaid Fee-for-Service (FFS). Covered services that are carved out of the Medicaid Health Plan (MHP) delivery system will be reimbursed through FFS consistent with applicable Medicaid policy.

9.1 GENERAL INFORMATION

Pediatric feeding disorders are a complex set of feeding and swallowing problems that disrupt the acquisition of functional age-appropriate feeding habits. To resolve complex pediatric feeding issues, clinical evidence indicates that both medical and behavioral interventions are needed. Failure to address feeding issues in young children can be severe and include growth failure, susceptibility to chronic illness, and/or death.

A Pediatric Outpatient Intensive Feeding Program is an onsite day program that is delivered by a team of medical, behavioral health and other professionals who address complex feeding issues through integrated, individualized care.

9.2 PROGRAM SERVICES

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies. Pediatric Outpatient Intensive Feeding Program services utilize a multi-disciplinary team to assist the beneficiary and their parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes. Pediatric Outpatient Intensive Feeding Program services include an initial comprehensive assessment, individualized plan of care (POC), on-going monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training. Pediatric Outpatient Intensive Feeding Program services offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services:

- Primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies;
- Utilize a multi-disciplinary team to assist the beneficiary and their parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes;

- Include an initial comprehensive assessment, individualized POC, ongoing monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training; and
- Offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Pediatric Outpatient Intensive Feeding Program services are designed to evaluate, diagnose and treat beneficiaries with significant feeding and swallowing difficulties. The initial comprehensive evaluation is performed by a multi-disciplinary team who meets with the beneficiary and their parents/guardians to assess the beneficiary's current status and potential for improvement. The initial comprehensive evaluation should include:

- Assessment of medical history and physical exam;
- Nutritional history and evaluation of growth and nutritional parameters;
- Psychological assessment of developmental, cognitive, emotional and behavioral function;
- Psychosocial evaluation;
- Evaluation of oral-motor function (may include videofluoroscopy swallow study, Fiberoptic Endoscopic Evaluation of Swallowing (FEES), clinical swallowing evaluation, and sensory evaluation);
- Standardized tests and/or objective functional baseline measures to assist with planning short- and long-term goals and to document progress;
- Observation of a simulated meal/snack time; and
- Development of an individualized POC.

Following the initial comprehensive evaluation, the beneficiary and their parents/guardians commit to an outpatient program which may typically be held five days per week, six to eight hours per day, for a period up to six weeks. The goals of Pediatric Outpatient Intensive Feeding Program services are to:

- Promote consistent mealtime acceptance;
- Promote good nutrition;
- Increase the variety of foods the beneficiary will eat;
- Promote development of oral-motor skills for feeding;
- Promote developmental feeding skills, such as cup drinking and self-feeding;
- Transition from tube to oral feeding; and
- Assist the beneficiary and/or parents/guardians in acquiring feeding skills through education/training.

Beneficiaries should be routinely monitored, and one-on-one consultations and/or conferences with team members should be routinely scheduled to discuss progress. Supportive services provided during this time may include speech therapy, occupational therapy, physical therapy and/or social work. Progress is assessed regularly and the POC is updated, if continuation is necessary.

9.3 Indications for Services

Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. Eligible beneficiaries must meet all the following criteria:

- Significant oral-motor problems and/or chronic medical condition exist;
- Normal feeding milestones have not been met through previous therapies and treatment;
- Suboptimal nutritional status has been determined; and
- Inadequate responsiveness to less intensive treatment has been clinically documented.

Examples of feeding disorders treated in these programs include, but are not limited to:

- Oral-motor dysfunction (including swallowing, oral and/or pharyngeal dysphagia);
- Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function;
- Gastrointestinal disorders; and
- Feeding tube dependency.

Pediatric Outpatient Intensive Feeding Program services are not covered for individuals with specific eating disorders (e.g., binge eating, bulimia, anorexia or obesity-related disorders).

9.4 Provider Qualifications

Pediatric Outpatient Intensive Feeding Programs are provided under the delegation and supervision of a Medical Director and delivered by a multi-disciplinary team of medical, behavioral health and other professionals who are licensed, certified and/or registered to provide health-related services within the scope of practice for their discipline. The multi-disciplinary team should integrate and coordinate an individualized, comprehensive POC to address complex feeding issues. Each Pediatric Outpatient Intensive Feeding Program must have the following staff actively involved in the assessment process and/or development/implementation of the POC.

Provider Type	Required Qualifications
Pediatrician	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Specialty Board Certification. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Subspecialist	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Subspecialty Board Certification, including physicians with special training and demonstrated clinical experience related to pediatric feeding clinic issues. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Licensed Behavioral Health Professional	A Licensed Behavioral Health Professional, such as a licensed psychologist or licensed Master's Social Worker, with at least two years of professional experience in providing services to children/youth and their families.

Provider Type	Required Qualifications
Occupational Therapist	A Licensed Occupational Therapist with at least one year of professional pediatric experience.
Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN)	An RD or RDN in possession of a Master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and one year of pediatric nutrition experience in providing nutrition assessment, education and counseling.
Speech-Language Pathologist	A Licensed Speech-Language Pathologist in possession of a Master's degree, and at least one year of professional pediatric experience.
Other staff	Other staff may include registered nurses, physical therapists, etc.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an active, participating team member in the development of the beneficiary's comprehensive POC.

9.5 Service Provider Enrollment

CSHCS-approved, Medicaid-enrolled program sites must be certified by the Michigan Department of Health and Human Services (MDHHS). MDHHS certification will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Assessment and POC services must be delivered by professional staff, as identified.
- If an aide under professional supervision delivers direct services, that supervision must be documented in the beneficiary's medical record.

Certification of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS or upon a site visit by MDHHS.

9.6 Prior Authorization

Pediatric Outpatient Intensive Feeding Program services require prior authorization. Requests for prior authorization must be submitted utilizing form MSA-6544-B (Practitioner Special Services Prior Approval – Request/Authorization) and include documentation to support medical necessity such as height/weight measurements and previously attempted therapeutic interventions. (Refer to the Prior Authorization subsection of the Practitioner Chapter for additional information.) Medicaid forms can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

A copy of the prior authorization must be retained in the beneficiary's medical record.

Pediatric Outpatient Intensive Feeding Program services must request prior authorization to continue intensive treatment services beyond the current authorization period, even if a beneficiary changes providers. A copy of the latest re-evaluation must be submitted with the prior authorization request.

Requests for continued treatment must be supported by all of the following:

- Summary of previous treatment period (not to exceed 90 days prior to that time period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes.

- Revised goals and justification for any change in the treatment plan for the requested period of treatment.
- Statement detailing any parent/guardian education and training.

9.7 Billing and Reimbursement

Reimbursement for Pediatric Outpatient Intensive Feeding Program services is a bundled payment rate based on the covered services provided by a multi-disciplinary team. This service is reimbursed as a daily rate comprised of all costs associated with the services provided within the day program, including: facility-related costs; medical care services provided by the physician and other licensed practitioners; services provided by clinical staff working under the delegation and supervision of a licensed medical practitioner; and diagnostic, screening and rehabilitative services. Services are billed as FFS claims through the Community Health Automated Medicaid Processing System (CHAMPS) regardless of beneficiary health plan status. Providers are to bill using Healthcare Common Procedure Coding System (HCPCS) code S0317 (disease management; per diem).

SECTION 10 – TARGETED CASE MANAGEMENT SERVICES FOR RECENTLY INCARCERATED BENEFICIARIES

10.1 GENERAL INFORMATION

Targeted case management (TCM) services are part of a comprehensive health benefit available to individuals with chronic or complex physical or behavioral health care needs and were recently released from an incarcerated setting. TCM services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities (e.g., education and supports).

10.2 BENEFICIARY ELIGIBILITY

TCM services are available to any beneficiary who is 18 years of age and older; meets Medicaid eligibility requirements; has a chronic or complex physical or behavioral health care need; and was a recent inmate or was involuntarily residing in a state prison or county jail. A recent inmate is an individual who was in custody and held involuntarily through operation of law enforcement authorities in an institution which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Eligible beneficiaries will be offered the choice of receiving the TCM services benefit. An initial in-reach visit may occur by a licensed registered nurse (RN), a fully licensed clinical social worker (LMSW), a community health worker (CHW), a peer support specialist (PSS), a peer recovery coach (PRC), or other licensed medical or behavioral health professionals operating within their state law defined scope of practice. The TCM services benefit includes a comprehensive assessment visit, development of a care plan, referrals and related activities, monitoring, and follow-up activities. Beneficiaries are eligible for TCM services for a period of 12 months. In addition to TCM services, eligible beneficiaries will receive the full array of Medicaid-covered benefits.

10.3 ACCESSING SERVICES VIA IN-REACH

TCM providers should conduct an in-reach visit in person when feasible. In-reach is a service provided to individuals prior to their release from an incarcerated setting to establish a relationship with a provider, identify health conditions, transition medical records, and set up community-based care. The TCM provider should review the information provided by prison or county jail personnel to verify the beneficiary's current Medicaid benefit plan and determine the appropriate process and team members (e.g., CHW, PSS, PRC, LMSW, or RN) to fulfill the in-reach service.

The in-reach visit should occur at least 7-14 calendar days, and no more than 30 calendar days, prior to the beneficiary's release from the incarcerated setting. The in-reach visit is to be provided face-to-face. Face-to-face is defined as either in-person or via telehealth (i.e., simultaneous audio and visual technology). Efforts should be made ahead of time to identify and address any accommodations needed by the beneficiary to support their access of the in-reach visit. The TCM provider must document the date of release and the date of the in-reach/initial contact in the beneficiary's medical record. The purpose of in-reach includes, but is not limited to:

- further educating the beneficiary regarding the TCM services program and answer any questions;

- collecting the beneficiary's demographic information, family contact information, criminal history, parole/probation officer information, current legal status, anticipated release date, and medical, behavioral health, and substance use disorder (SUD) history;
- collecting information regarding where the beneficiary plans to reside upon release from incarceration and how they can be contacted;
- coordinating medication-assisted treatment (MAT) to continue needed prescriptions and other immediate needs upon release from incarceration; and
- scheduling the initial in-person comprehensive assessment visit with the qualified case manager within 90 days of release from the prison or county jail.

10.3.A. Prison and County Jail In-Reach Process

The qualified health professional (QHP) or qualified mental health professional (QMHP) from the prison, or the county jail medical and/or behavioral health staff, will identify Medicaid-eligible beneficiaries that may qualify for the TCM benefit. The recommendation for a beneficiary to participate in the TCM benefit should be based on an assessment of their chronic and/or complex physical and/or behavioral health care needs.

The QHP, QMHP, or county jail personnel should share information regarding the details of the TCM services program with the beneficiary and offer them a choice to participate in the benefit. The beneficiary should be provided with a list of available choices of TCM providers in the area they plan to reside once released.

Once the beneficiary chooses a TCM provider, the QHP, QMHP, or county jail personnel will reach out to the provider to coordinate a face-to-face in-reach visit with a qualified case manager, CHW, PSS, or PRC that the TCM provider has identified to furnish the visit. The TCM provider should follow-up with the prison or county jail within three (3) business days of being contacted.

Referrals for TCM should be coordinated among the available TCM providers in the community, and these services should be rendered in the most appropriate setting. For example, a referral to a federally qualified health center (FQHC) or other clinic setting may be a more appropriate setting to address a medical or physical health care need; whereas a certified community behavioral health clinic (CCBHC) or community mental health services program (CMHSP) may be more appropriate to address a beneficiary's behavioral health care need.

Prior to the in-reach visit, the QHP or QMHP from the prison or the county jail personnel should verify the beneficiary's Medicaid status and forward a pre-screen form that includes the beneficiary's name, Medicaid ID number, date of birth, contact information, family contact information, demographics, parole/probation officer contact information, anticipated release date, and health history to the TCM provider. In addition, visiting staff from the TCM provider are required to complete a Law Enforcement Information Network (LEIN) security clearance form prior to entering the prison setting.

10.4 Core Elements of TCM Services

TCM services must include coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid health plan (MHP), as applicable. The purpose of TCM services is to provide a comprehensive array of services that are appropriate to the conditions of the beneficiary. At a minimum, TCM services must include:

- an in-person comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individualized care plan;
- referral, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services; and
- coordination with the beneficiary's PCP, other providers, and MHP, as applicable.

10.4.A. Comprehensive Assessment Visit

The beneficiary must be offered the choice to participate in the TCM services benefit program or any another program that provides a similar case management benefit that they may qualify for. Beneficiaries are not restricted from receiving case management services from any qualified Medicaid provider.

A qualified case manager (e.g., licensed nurse or clinical social worker) should perform an in-person comprehensive assessment visit within 90 days after the beneficiary is released from the prison or county jail. The comprehensive assessment visit is limited to one (1) visit per beneficiary throughout each 12-month period of eligibility following release from an incarcerated setting.

During the initial visit, the qualified case manager must verify the beneficiary's Medicaid eligibility and coverage by utilizing the Benefit Plan ID(s) provided in the Community Health Automated Medicaid Processing System (CHAMPS) eligibility response. (Refer to the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.) The qualified case manager should contact MDHHS Provider Support to have the benefit plan updated to end the Medicaid incarceration benefit plan restrictions, if needed. (Refer to the Directory Appendix for Targeted Case Management Services for Recently Incarcerated Beneficiaries for contact information.) Information should include the following:

- beneficiary's name, Medicaid ID number, and date of birth;
- beneficiary's incarceration release date;
- incarceration facility name;
- claims information, if applicable; and
- information regarding documentation/proof of discharge that was uploaded into the Document Management Portal (DMP) (e.g., release paper or Offender Tracking and Information System (OTIS) screenshot).

The DMP is a tool in CHAMPS that allows providers and billers to upload documents and submit supporting documentation electronically for Medicaid electronic claims. (Refer to the Directory Appendix for more information and tutorials regarding the Document Management Portal.)

The purpose of the comprehensive assessment visit is to gather sufficient information to develop an individualized care plan for the beneficiary. Initial comprehensive assessment activities include, but are not limited to, the following:

- taking a beneficiary's history;
- identifying the beneficiary's needs and completing related documentation;
- gathering information from the beneficiary and other chosen sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the beneficiary;
- assessment of the beneficiary's access to a PCP and other healthcare providers;
- assessment of the beneficiary's dental needs;
- assessment of the beneficiary's access to transportation;
- supporting the beneficiary in the timely completion of MHP enrollment using the Michigan ENROLLS established process;
- identifying available community-based resources;
- facilitating and coordinating referrals and related activities;
- scheduling a medical visit with a physician to address immediate health care needs if necessary, or coordinating with the beneficiary's chosen MHP to schedule a medical visit with their PCP within 30 days of the beneficiary's release from an incarcerated setting; and
- coordinating any necessary substance abuse or behavioral health assessments and related services needed with the prepaid inpatient health plan (PIHP)/CMHSP.

10.4.B. Development of the Care Plan and Documentation

During or immediately following the in-person initial comprehensive assessment visit, a specific care plan that is based on the information collected through the initial comprehensive assessment must be developed for beneficiaries who agree to participate in the TCM services program. The care plan must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The qualified case manager must work with the beneficiary and others chosen by the beneficiary to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The care plan should address the physical and behavioral health needs of the beneficiary, along with any other needed resources such as housing, energy assistance, food and nutrition, vocational training, cultural and spiritual needs, and transportation needs. The care plan should be shared with the beneficiary's MHP, PCP and PIHP, as applicable, to the extent permitted under all applicable state and federal laws.

TCM providers are required to document the following information for all beneficiaries receiving TCM services:

- name of the beneficiary;
- dates of the TCM services;
- name of the TCM provider and qualified case manager providing TCM services;
- nature and content of the TCM service visits conducted, and whether goals specified in the care plan were achieved;
- whether the beneficiary has declined services proposed within the care plan;
- plan monitoring and follow-up to include activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible beneficiary's needs;
- estimating the frequency of the monitoring and follow-up visits to adequately meet the needs and wants of the beneficiary during the 12 months of eligibility;
- the need for, and occurrences of, coordination with other providers;
- timeline for obtaining needed services;
- timeline for re-evaluation of the care plan; and
- update of the care plan as needed.

10.4.C. Referrals and Related Activities

In collaboration with the PCP and the MHP, it is expected that the qualified case manager will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services of their choosing. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other providers, programs, and services to address identified needs and achieve goals specified in the care plan are primary components of TCM services. Referral activities include, but are not limited to, the coordination of the following:

- medical/physical and behavioral healthcare services;
- dental services;
- SUD services;
- transportation services;
- nutritional and food services and resources (e.g., diabetes education, obesity reduction and prevention, and/or coordinating referrals to the Supplemental Nutrition Assistance Program [SNAP], Women, Infants, and Children [WIC] Program or Food Assistance Program [FAP]);
- housing and energy assistance;
- education resources;
- employment, job training, vocational rehabilitation, or other financial services; and

- any additional social supports and services to assist the beneficiary in obtaining other needed services and assistance.

10.4.D. Monitoring and Follow-Up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or other beneficiaries of their choosing. Monitoring and follow-up activities are conducted as frequently as necessary throughout each 12-month period of eligibility following release from an incarcerated setting.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers. The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope of case management monitoring activities must reflect the intensity of the beneficiary's physical health, behavioral health, and welfare needs identified in the beneficiary's care plan.

10.4.D.1. Monitoring Visits

Monitoring visits are provided by a qualified case manager and may or may not require face-to-face interaction. Monitoring visits are limited to 11 visits throughout each 12-month period of eligibility following release from an incarcerated setting.

Monitoring visits are provided to ensure the beneficiary's needs are being met. Monitoring activities include, but are not limited to, addressing that:

- services are being furnished in accordance with the beneficiary's care plan;
- services in the care plan are adequate;
- changes in the needs or status of the beneficiary are reflected in the care plan;
- the beneficiary has received a medical/physical health visit by a physician or non-physician practitioner (NPP) and is receiving appropriate follow-up services, if necessary;
- the beneficiary has received a behavioral health assessment visit by a behavioral health specialist and is receiving appropriate follow-up services, if necessary;
- the beneficiary has been screened for SUD and has been referred to the PIHP for any treatment services, if necessary;
- the beneficiary's dental needs are being met;
- the beneficiary's transportation needs are being met;
- the beneficiary is residing in a safe and accessible environment (e.g., house, apartment, etc.);
- the beneficiary has access to daily food and nutritional needs;
- the beneficiary has been offered or is engaging in some type of education, vocational rehabilitation, and/or job training; and/or
- the beneficiary is being facilitated in a job search.

10.4.D.2. Follow-Up Activities

Follow-up activities include education and support visits that may be provided by a qualified case manager or another professional under the supervision of the qualified case manager, such as a CHW, PSS, or a PRC. Education and support visits may or may not require face-to-face interaction and they are limited to 11 visits throughout each 12-month period of eligibility following release from an incarcerated setting. Education and support services include activities that are necessary to ensure the beneficiary receives personalized assistance and guidance in navigating the healthcare system and numerous other needed resources and services. Education and support services include activities to support the beneficiary in attaining their goals identified in the care plan and include, but are not limited to, the following:

- verify the beneficiary's Medicaid eligibility and coverage by utilizing the Benefit Plan ID(s) provided in the CHAMPS eligibility response. (Refer to the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.) The qualified case manager, or another professional under the supervision of the qualified case manager, should contact MDHHS Provider Support to have the benefit plan updated to end the Medicaid incarceration benefit plan restrictions, if needed. (Refer to the Directory Appendix for Targeted Case Management Services for Recently Incarcerated Beneficiaries for contact information.)
- facilitate the care plan;
- encourage the beneficiary to receive a medical/physical health visit by a physician or NPP, as well as appropriate follow-up services if necessary;
- encourage the beneficiary to receive a dental visit;
- meet regularly with the TCM provider healthcare team to plan care, and exchange information with other healthcare team members;
- follow-up with the beneficiary one to two weeks following the medical visit with the PCP;
- coordinate with the beneficiary's parole/probation officer to identify and assist the beneficiary in accessing community resources and social services (e.g., smoking cessation programs, food assistance, energy assistance, transportation, legal services, etc.);
- coordinate with the beneficiary's parole/probation officer to identify housing assistance and provide support locating and acquiring appropriate housing for achieving independent living (e.g., assisting with Section 8 Housing voucher applications);
- provide vocational assistance and support by aiding the beneficiary in seeking education and/or training opportunities, job seeking, developing self employment opportunities, etc.
- facilitate health education and support groups;
- provide support in accessing religious services and/or cultural services;
- provide support in accessing veteran services;
- provide support in accessing assistive technologies and services;
- develop, implement, and provide health, wellness, and prevention initiatives to address preventable risk factors for chronic conditions;

- provide education on health conditions and strategies to implement care plan goals, including both clinical and non-clinical needs;
- reduce barriers to care coordination;
- promote healthy lifestyle interventions;
- encourage routine preventive care, such as immunizations and screenings;
- educate the beneficiary in the management of chronic conditions;
- track test results;
- facilitate adherence to treatment;
- inquire if there are any issues taking medications or getting prescriptions filled;
- assist the beneficiary in making informed decisions;
- facilitate coordination between various services and providers;
- notify the MHP case manager when visits have been scheduled;
- assist with scheduling appointments, including coordinating transportation;
- coordinate and track referrals to community and social supports; and
- advocate for any of the beneficiary's needs.

10.5 Targeted Case Management (TCM) Provider Qualifications

The TCM provider must be enrolled as a Michigan Medicaid provider and have the ability to demonstrate the following criteria:

- the capacity to provide all core elements of case management services, including:
  - comprehensive beneficiary assessment;
  - comprehensive care plan development;
  - linking/coordination of services;
  - monitoring and follow-up of services; and
  - reassessment of the beneficiary's status and needs;
- case management experience in coordinating and linking such community resources as required by the target population;
- experience with the target population;
- the sufficient number of staff to meet the case management service needs of the target population;
- an administrative capacity to ensure quality of services in accordance with state and federal requirements;
- a financial management capacity and system that provides a record of services and costs;
- the capacity to document and maintain beneficiary case records in accordance with state and federal requirements; and

- has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable.

Providers that may enroll through CHAMPS as a TCM provider for recently incarcerated beneficiaries may be a:

- Community Mental Health Services Program (CMHSP);
- Federally Qualified Health Center (FQHC);
- Rural Health Clinic (RHC);
- Tribal Health Center (THC); or
- Tribal Federally Qualified Health Center (Tribal FQHC).

CCBHCs can provide similar TCM services for beneficiaries; however, CCBHCs will not enroll through CHAMPS as a TCM provider for recently incarcerated beneficiaries. CCBHCs are certified by MDHHS to provide a robust set of coordinated, integrated, and comprehensive services (including TCM) to beneficiaries with any mental or SUD diagnosis. A CMHSP may be enrolled as both a CCBHC and as a TCM provider; however, any similar case management services cannot be furnished by more than one organization or program for a single beneficiary.

The TCM provider must have the capability to coordinate with the beneficiary's health plan and the individual facilitating the re-entry from the prison or county jail. The TCM provider must employ a qualified case manager who is licensed to practice in accordance with Michigan law. Documentation of the provider's qualifications and credentials must be maintained by the TCM provider. The documentation indicates that the provider is qualified to furnish TCM services based on education and experience. The TCM provider must have a health information technology (HIT) record system, policies, procedures, and practices to create, document, execute, and update plans of care for the beneficiary.

Michigan Medicaid enrolled providers are required to sign an attestation document indicating they are able to meet the requirements of the TCM provider qualifications to be officially recognized as a TCM provider. Providers must sign the attestation agreeing to adhere to this policy and all applicable laws and return the attestation form to MDHHS. A provider may become designated as a TCM provider only after MDHHS receives, and approves, the signed attestation which may be returned through the "Upload Documents" section of the CHAMPS Provider Enrollment subsystem. (Refer to the Provider Enrollment section of the General Information for Providers chapter for additional information.) (Refer to the Directory Appendix for Targeted Case Management Services for Recently Incarcerated Beneficiaries for the attestation document located on the website.)

10.5.A. Qualified Case Managers

Qualified case managers may provide all components of TCM within their scope of practice. A qualified case manager must meet one of the following criteria:

- licensure as a Registered Nurse by LARA and at least one year of experience providing community health or case management services; or
- licensure as a fully licensed Clinical Social Worker by LARA and at least one year of experience providing social work or case management services.

In collaboration with the treating physician or NPP, the qualified case manager provides an assessment of needs; develops and maintains a care plan; manages care transitions; provides education and support to the beneficiary; identifies community mental health, SUD, and physical health resources; and facilitates access to care, supports, and services. TCM services are provided by a multi-disciplinary team of licensed medical and behavioral health professionals operating within their state law defined scope of practice. Licensed providers assume professional responsibility for the services provided by any unlicensed practitioner (e.g., CHW, PSS, PRC, etc.).

10.5.B. Physician or Non-Physician Practitioner (NPP)

A Medicaid-enrolled physician or NPP licensed by LARA must provide general supervision of the qualified case manager. An NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist.

10.5.C. Community Health Workers (CHWs)

The TCM provider may include the services of a CHW. CHWs are professionals who are defined by the American Public Health Association (APHA) as frontline public health workers who understand the community they serve. The CHW serves as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. CHWs also work to increase a beneficiary's health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy.

CHWs may serve as a liaison between the penal system, the healthcare system, and the community, and they work to facilitate access to services and improve the quality and cultural competence of service delivery. The CHW may also coach beneficiaries in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist beneficiaries with completion of applications for programs for which they may be eligible. A CHW must work in collaboration with the beneficiary's qualified case manager and must:

- be at least 18 years of age;
- possess a high school diploma or equivalent;
- be supervised by licensed professional members of the care team; and
- complete a CHW Certificate Program or equivalent.

10.5.D. Peer Support Specialists (PSS) and Peer Recovery Coaches (PRC)

The TCM provider may include the services of PSSs and/or PRCs. A PSS and/or PRC must work in collaboration with the beneficiary's qualified case manager, and must:

- be supervised by licensed professional members of the care team;
- be freely chosen by the beneficiary; and

- meet the MDHHS application approval process for specialized training and certification requirements;

Refer to the Covered Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for more information. (Refer to the Directory Appendix for Peer Recovery Information website information.)

10.6 Transfer of Care/Records

During the course of care, the beneficiary may require services from a different TCM provider due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change TCM providers. The referring TCM provider must consult with the new TCM provider about the case and transfer all applicable information and records, including all completed assessment visits and the updated care plan, to the new TCM provider in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code.

10.7 TCM Closure

TCM services are considered complete when any of the following occurs:

- the beneficiary's eligibility of 12 months has expired;
- the beneficiary has received the allowable number of TCM services over a 12-month time period;
- the beneficiary communicates the desire to terminate or refuse TCM services to the TCM provider; or
- the beneficiary becomes non-adherent or non-compliant with the care plan or TCM provider.

When services are terminated or refused, TCM services may be resumed at any point during the defined 12-month period of eligibility. Upon completion of TCM services, a completed care plan, including discharge summary (including the services provided, outcomes, current status, and ongoing needs of the beneficiary) must be shared with the PCP, PIHP, MHP case manager, and beneficiary in alignment with confidentiality laws and regulations when the TCM case is closed.

10.8 Covered Supports and Services

A maximum of 23 visits per year will be reimbursed for each eligible beneficiary as follows:

- one in-person visit for the initial comprehensive assessment;
- a maximum of 11 face-to-face and/or non-face-to-face monitoring visits; and
- a maximum of 11 face-to-face and/or non-face-to-face follow-up (patient education and supports) visits.

If the beneficiary returns to incarceration and is then once again released, their period of eligibility will start over, but the remainder of their monitoring and follow-up visits will not be renewed. For additional visits, MDHHS requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix for contact information regarding prior authorizations.)

Reimbursement for assessment, monitoring, and follow-up visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit. Medicaid reimbursement for TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. To avoid duplication of services, TCM services should not be provided to beneficiaries receiving the following Medicaid program services:

- MI Care Team Health Home benefit;
- Behavioral Health Home benefit;
- Substance Use Disorder Health Home benefit;
- Collaborative Care Management services; or
- Other case management benefit programs that provide similar services.

The TCM provider must have an established process to coordinate services for beneficiaries who may be covered under another program which offers components of case management or coordination similar to TCM. TCM does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred.

TCM coordination includes contacts with non-eligible beneficiaries when the contact is:

- directly related to identifying the eligible beneficiary's needs and care for the purpose of assisting the beneficiary in accessing services;
- identifying needs and supports to assist the beneficiary in obtaining services;
- providing case managers with useful feedback; and
- alerting case managers to changes in the beneficiary's needs.

10.9 Claims Submission and Payment

Providers may verify beneficiary eligibility for TCM services through a CHAMPS online eligibility inquiry or via a HIPAA 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for TCM services will show a current benefit plan of "TCM-INC" in addition to their assigned Medicaid-related benefit plans. All claims submitted and accepted are processed through CHAMPS. TCM services are carved out of the MHP's capitation and are billed and reimbursed as a fee-for-service benefit.

CMHSPs furnishing TCM services must submit claims on the professional format. FQHCs, RHCs, THCs, and Tribal FQHCs must submit claims on the institutional format. FQHCs, RHCs, THCs, and Tribal FQHCs furnishing TCM services will be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology at the Medicaid fee screen reimbursement rates for TCM services for recently incarcerated beneficiaries. All providers reported on claims for services must be Medicaid-enrolled. (Refer to the Targeted Case Management for Recently Incarcerated Fee Schedule in the Special Programs database on the MDHHS website. Refer to the Directory Appendix for website information.)

Providers participating as an MDHHS-certified CCBHC do not enroll through CHAMPS as a TCM service provider for recently incarcerated beneficiaries. CCBHCs enroll in a separate program and are reimbursed through a PPS methodology in which they receive a daily clinic-specific rate based on the average expected daily cost to deliver core CCBHC services which includes TCM services for recently incarcerated

beneficiaries. (Refer to the Certified Community Behavioral Health Clinic Demonstration section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for more information.)

Upon release of the beneficiary from a county jail setting, the benefit plan should update to end the Medicaid incarceration restrictions. If this update does not occur, the TCM provider (e.g., qualified case manager) should contact MDHHS Provider Support to end the Medicaid incarceration benefit plan restrictions. The TCM provider may also coordinate with the corrections personnel to contact the local MDHHS office to ensure the Living Arrangement page within MI Bridges is correctly updated to end the program enrollment type (PET) code of "INC-Jail". Once the "INC-Jail" PET code ends, the TCM PET code of "TCMR-INC" will be automatically added to the beneficiary's benefit plan. Upon release of the beneficiary from a prison setting, the benefit plan should switch to the new TCM benefit plan and be updated automatically. The TCM provider should verify that the switch has occurred prior to rendering services.

10.9.A. Initial Comprehensive Assessment

The initial comprehensive assessment is to be provided in-person by a qualified case manager. The initial comprehensive assessment visit should require at least 60 minutes. Only one initial comprehensive assessment visit is allowed. Reimbursement includes time for the development of a care plan. Federal law prohibits the use of Medicaid funds to cover services, including in-reach, for inmates of public institutions (with the exception of inpatient hospital services).

10.9.B. Monitoring Visits

Monitoring visits are to be provided face-to-face and/or non-face-to-face by a qualified case manager. Monitoring visits should require at least 60 minutes. A maximum of 11 face-to face and/or non-face-to-face monitoring visits per year are allowed. Additional monitoring visits which may be needed require prior authorization.

10.9.C. Follow-Up Activities/Patient Education and Supports

Follow-up activities, including patient education and support visits, are to be provided face-to-face and/or non-face-to-face by a qualified case manager, CHW, PSS, or PRC. Follow-up visits should require at least 30 minutes. A maximum of 11 in-person face-to face and/or non-face-to-face follow-up visits per year are allowed. Additional follow-up visits which may be needed require prior authorization. Qualified case managers assume professional responsibility and supervision for follow-up visits that are provided by a CHW, PSS, or PRC.

SECTION 11 – TARGETED CASE MANAGEMENT – RECUPERATIVE CARE

11.1 GENERAL INFORMATION

Targeted Case Management (TCM) – Recuperative Care (RC) is a transitional program for Medicaid beneficiaries meeting eligibility requirements who are experiencing homelessness and discharging from an inpatient hospital admission. RC is a short-term program that allows these beneficiaries to recover post-hospitalization, receive case management services, access medical care or other Medicaid services, and receive supportive services.

11.2 PROVIDER REQUIREMENTS

The RC provider must be an enrolled Medicaid provider. The RC provider must meet the National Institute for Medical Respite Care (NIMRC) standards for medical respite care. (Refer to the Directory Appendix for website information.)

The RC provider must have:

- Private or semi-private rooms for Medicaid beneficiaries;
- Allow 24-hour access to rooms;
- Clean linens for each beneficiary upon admission;
- At least three meals per day must be provided;
- Secure place to store personal belongings;
- Secure medication storage accessible by the beneficiary;
- Appropriate storage for all durable medical equipment (DME);
- On-site access to laundry and shower facilities;
- 24-hour access to staff, and staff on-site who are minimally trained in first aid and basic life support on-site at all times;
- Written policies to allow beneficiary visitors to enter the facility/room;
- Written policies and procedures for life-threatening emergencies; and
- A facility that is compliant with local and state fire safety standards.

11.2.A. PROVIDER ENROLLMENT

Recuperative care (RC) providers seeking reimbursement for their services to Medicaid beneficiaries are required to be Medicaid-enrolled providers. To enroll as a Medicaid provider, an RC provider must obtain a Type 2 (Organization) National Provider Identifier (NPI) and complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS).

The RC provider must meet NIMRC standards for medical respite care programs. The RC provider must complete the Michigan Recuperative Care Provider Attestation form (BPHASA-2428) attesting to meeting these requirements and provide any requested documentation to MDHHS to enroll as an RC provider. RC providers must complete the

attestation every three years. RC providers must revalidate every five years. Failure to complete these requirements will result in the RC provider being terminated as a Medicaid RC provider. (Refer to the Forms Appendix for a copy of the form.)

CHAMPS enrollment instructions can be found on the MDHHS website Provider Enrollment page. RC providers are subject to all relevant policy provisions outlined in the MDHHS Medicaid Provider Manual, including the General Information for Providers chapter.

11.3 Beneficiary Eligibility

RC is covered for Medicaid-enrolled homeless beneficiaries over 18 years old enrolled in fee-for-service (FFS) Medicaid, Healthy Michigan Plan and Managed Care. Emergency Services Only Medicaid, Plan First, and other limited coverage plans are excluded from coverage for recuperative care.

To be eligible for RC services, the beneficiary must be homeless and discharging from an inpatient hospital stay. The beneficiary must have a need for ongoing case management and support but is not eligible for continued hospitalization or another inpatient or higher acuity setting (such as a nursing facility).

The beneficiary must meet all the following for services to be authorized:

- The beneficiary must be homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (24 CFR §578.3).
- Beneficiaries must be discharging from an inpatient hospital admission with an acute condition that can be addressed in less than 90 days.
- Beneficiaries must be medically stable, independently mobile, and be able to manage and perform their own activities of daily living (ADLs).
  - The beneficiary is able to complete ADLs (such as transfers, bed mobility, eating, toileting, etc.) without physical assistance, cueing, or supervision.
  - If a beneficiary does not meet this requirement, they may be eligible for other Medicaid services (e.g. nursing facility) and should be referred for these services.
- Beneficiaries must be able to manage medications, durable medical equipment, and medical supplies independently.
- Beneficiaries must have a need for case management and supportive services.
- Beneficiaries must be at risk for re-hospitalization or severe complications without the support of RC services.
- The beneficiary is not eligible for continued hospital admission, skilled nursing facility admission, in-patient psychiatric admission, or other Medicaid inpatient services.

Recuperative Care is not to supplant skilled nursing admission, behavioral health services, or other higher acuity settings for which the beneficiary is eligible.

11.4 Prior Authorization

Recuperative services must be authorized by the MDHHS Program Review Division (PRD) prior to the start of services for all beneficiaries. RC providers must contact PRD Recuperative Care to complete a telephonic request for prior authorization (PA) and receive authorization before the start of services. (Refer to the Directory Appendix for contact information.)

RC services are authorized and billed per day. RC coverage will not exceed 90 days per hospital discharge.

RC providers must complete the Recuperative Care (RC) Prior Authorization (PA) Request Data form (BPHASA-2427) prior to requesting PA for Medicaid beneficiaries and maintain it in the beneficiary's record. (Refer to the Forms Appendix for a copy of the form.)

The following documents must be readily accessible for reference by the provider during the telephonic review:

- Completed Recuperative Care Prior Authorization Request Data form (BPHASA-2427);
- Most recent history and physical examination;
- Social work notes/assessment, including status as it relates to ineligibility for nursing facility, in-patient psychiatric, or other inpatient Medicaid services;
- Hospital consultation reports;
- Emergency department notes, if applicable;
- Most recent updated plan of care (POC) signed and dated by the ordering/managing physician;
- Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their baseline status, completed by a registered nurse;
- Physical therapy and/or occupational therapy assessment, including a summary of the beneficiary's current functional status or level of functional independence with ADLs, DME and medication management;
- Hospital discharge plan (completed within two days of the PA request), including anticipated discharge orders for services such as medical follow-up, durable medical equipment/supplies, medications, and pharmaceuticals;
- Documentation that the beneficiary is homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (24 CFR §578.3); and
- Anticipated admission date and discharge date from the RC facility.

For FFS beneficiaries, the PA must be obtained from PRD for care coordination (G9002) and room & board (S9976).

For Medicaid Health Plan (MHP) beneficiaries, the PA must be obtained from PRD for room & board (S9976) and the MHP must be contacted for PA for care coordination (G9002).

11.4.A. PA Approval

If RC services are approved by PRD, the provider will be issued an authorization number and end date at the conclusion of the telephonic request. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To ensure payment, the provider must verify beneficiary eligibility monthly at a minimum.

If a beneficiary is re-hospitalized during a PA period, upon discharge, RC services may be resumed with the same RC provider without requiring a new PA. Extension of a PA interrupted by a re-hospitalization will be reviewed and considered on an individual basis. Extension of a PA beyond 90 days will be considered on an individual basis.

11.4.B. PA Denial

If services are denied by PRD, the RC provider will be informed of the denial. The beneficiary will be sent a letter notifying them of the denial with an explanation of their appeal rights. The denial letter will be sent to the beneficiary's address on record in CHAMPS, and a copy of the letter will be sent to the RC provider.

11.5 Covered Services

The purpose of RC services is to provide a comprehensive array of case management services that are appropriate to the conditions of the beneficiary, and to provide room and board. At a minimum, RC services must include:

- An in-person comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual POC;
- Planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;
- Assistance in establishing permanent housing;
- Coordination with the beneficiary's primary care provider (PCP), other providers, and MHP, as applicable; and
- Room and Board.

11.5.A. Comprehensive Assessment

The comprehensive initial assessment, and periodic reassessment, must be completed in-person by a qualified case manager. The initial assessment must be completed within two days of admission to the RC provider. In-person reassessment must be completed at least quarterly, or when there is a significant change in the beneficiary's condition or significant changes within the beneficiary's support network.

The comprehensive assessment must include, but is not limited to:

- Beneficiary's history;

- Identifying beneficiary's needs and completing related documentation;
- Identifying community-based resources the beneficiary currently accesses;
- Gathering information from the beneficiary and other chosen sources, such as family members, medical providers, social workers, to form a complete assessment of the beneficiary;
- Assessment of the beneficiary's current access to a PCP and other health care providers;
- Assessment of the beneficiary's current access to transportation; and
- Assessment of the beneficiary's living arrangement prior to admission.

11.5.B. Plan of Care

During or within two calendar days following the in-person initial comprehensive assessment visit, a specific POC that is based on the information collected through the assessment must be developed. The POC must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The qualified case manager must work with the beneficiary and others chosen by the beneficiary to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary.

The POC should address the physical and behavioral health needs of the beneficiary, along with any other needed resources such as housing, energy assistance, food and nutrition, vocational and training, cultural and spiritual needs, and transportation needs. The POC must be updated when the beneficiary is reassessed or has a significant change in condition. The POC should be shared with the beneficiary's MHP, PCP and Prepaid Inpatient Health Plan (PIHP), as applicable, to the extent permitted under all applicable state and federal laws.

11.5.C. Referrals and Related Activities

The qualified case manager will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services of their choosing. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other providers, programs, and services to address identified needs and achieve goals specified in the POC are primary components of RC services. Referral activities include, but are not limited to, the coordination of the following:

- medical/physical and behavioral healthcare services;
- dental services;
- Substance use disorder (SUD) services;
- transportation services;
- housing support and services;
- nutritional and food services and resources (e.g., diabetes education) and/or coordinating referrals to the Supplemental Nutrition Assistance Program (SNAP), Women, Infants, and Children (WIC) or Food Assistance Program (FAP);

- education resources;
- employment, job training, vocational rehabilitation, or other financial services; and
- any additional social supports and services to assist the beneficiary in obtaining other needed services and assistance.

11.5.D. Monitoring and Follow-up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the POC is implemented and adequately addresses the beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted at least once in the six months following discharge, or as frequently as necessary as determined by the qualified case manager, and may be completed in-person or virtually. Monitoring and follow-up activities should determine whether the following conditions are met:

- Services are being furnished in accordance with the beneficiary's POC; and
- Services in the POC are adequate.

Referrals to appropriate community providers should be made if current services in the POC are not adequate.

11.6 Qualified Case Manager

Qualified case managers may provide all components of RC services within their scope of practice. A qualified case manager must meet one of the following criteria:

- Licensure as a Registered Nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA) and at least one year of experience providing community health or case management services; or
- Licensure as a fully licensed Clinical Social Worker by LARA and at least one year of experience providing social work or case management services.

A Medicaid-enrolled physician or non-physician practitioner (NPP) licensed by LARA must provide general supervision of the case manager. An NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist.

11.7 Non-Covered Services

The services listed below are not covered through RC services:

11.7.A. Professional Services

Professional services are not covered by RC. Professional services or other Medicaid-covered services must be provided and billed by the appropriately enrolled Medicaid provider.

11.7.B. Durable Medical Equipment and Medical Supplies

Durable medical equipment (DME) and medical supplies are not covered by RC. DME and medical supplies must be ordered and provided as if the beneficiary was in their own home. RC providers are required to provide safe storage for all necessary DME and medical supply items.

11.8 Coordination of Services

The RC provider must ensure coordination in the delivery of services through an integrated process across all aspects of Medicaid services. Integrated services encompass communication from all physicians and disciplines (e.g., skilled nursing and therapy services) as well as other entities (e.g., Home Health, MI Choice Waiver). The RC provider must also provide ongoing training and education for the beneficiary and caregiver with respect to the care and services identified in the POC, as well as for the safe transfer into or discharge from community services. Throughout the care planning process, it is the responsibility of the RC provider to ensure coordination of care and to avoid duplication of services (e.g., Home Health, MI Choice Waiver).

11.9 Discharge from Service

RC providers must ensure either one of the following before discharging a beneficiary from RC services:

- The beneficiary's medical condition has improved.
- The beneficiary is being discharged to another setting that can meet their needs.

Note: The beneficiary may choose to discharge at any time or with no housing option if that is their choice.

11.10 Billing Requirements

RC claims are submitted by the Medicaid-enrolled RC provider. Claims are submitted on a professional claim format and must include an approved RC Healthcare Common Procedure Coding System (HCPCS) code.

Covered RC procedure codes, rates and code descriptions are listed below and maintained on the RC fee schedule located on the MDHHS website. (Refer to the Directory Appendix for website information.)

RC services are to be billed as follows:

- S9976 (lodging per diem), 1 unit/visit per day
- G9002 (care coordination), 1 unit/visit per day

The PA number must be recorded on the claim.

RC services must be billed based upon the beneficiary's enrollment.

For care coordination (G9002), if the beneficiary is enrolled in a MHP, it should be billed to the MHP. If the beneficiary is FFS, it should be billed through CHAMPS as an FFS claim.

For room and board (S9976), both MHP and FFS enrolled beneficiary claims should be submitted through CHAMPS for Medicaid FFS reimbursement.

PA requirements apply to MHP and FFS claims for RC services.

11.10.A. Billed Days of Admission

Day of Admission Medicaid reimburses the day of admission if the beneficiary is in the facility prior to midnight.

Day of Discharge Medicaid does not reimburse the day of discharge.

SECTION 12 - TARGETED CASE MANAGEMENT - SERVICES FOR CHILDREN WITH MEDICAL COMPLEXITY [SECTION ADDED 4/1/2025]

12.1 GENERAL INFORMATION [SUBSECTION ADDED 4/1/2025]

The Children with Medical Complexity – Targeted Case Management (CMC TCM) program provides intensive, targeted case management services to eligible beneficiaries with medical complexity. This integrated case management model improves access to services for eligible beneficiaries with chronic physical and mental health conditions and addresses their social determinants of health. The core elements of CMC TCM services include assessment, individualized plan of care (IPOC), referral and coordination services, and monitoring/follow-up activities.

These services are made available through a case management entity. The CMC TCM case management entity offers outpatient, case management to eligible beneficiaries with medical complexity. The CMC TCM case management entity must be enrolled in Medicaid and not otherwise funded to provide similar services to the same population. The CMC TCM case management entity must be willing, qualified, and certified by the Michigan Department of Health and Human Services (MDHHS) to offer these services to a broad cross section of the eligible population.

The CMC TCM core team is the multi-disciplinary team based at the enrolled CMC TCM case management entity that delivers the CMC TCM services. Eligible beneficiaries work with the CMC TCM core team to receive the intensive case management services. **(text added per bulletin MMP 24-61)**

12.2 BENEFICIARY ELIGIBILITY [SUBSECTION ADDED 4/1/2025]

CMC TCM services are voluntary services available to children under 21 years of age who are determined dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid, are enrolled in the CSHCS program only, or are eligible for Medicaid or Children's Health Insurance Program (CHIP). Additionally, they must meet all the following specified chronicity, complexity, and fragility criteria:

- have at least one CSHCS medically eligible condition that involves three or more organ systems; and
- have functional limitations, and are technologically dependent and/or a transplant candidate; and
- receive treatment from three or more different medical and/or surgical specialties at a hospital or medical university.

Eligible beneficiaries must also have experienced at least one of the following utilization criteria during the previous 12 months:

- one or more hospital admissions, with at least one hospital stay of five or more days; or
- ten or more visits with a medical or surgical specialist at a pediatric specialty clinic.

Beneficiaries who are too young to have met the utilization criteria may be eligible if they meet the above-stated chronicity, complexity, and fragility criteria and both of the following:

- a stay in the hospital totaling five or more days; and

- clinicians' anticipation that the beneficiary will be an intensive user of health resources (i.e., is expected to meet utilization criteria described above).

Non-eligible beneficiaries include incarcerated individuals in public institutions, beneficiaries receiving hospice services, or beneficiaries receiving case management services from another provider. **(text added per bulletin MMP 24-61)**

12.3 Enrollment [Subsection Added 4/1/2025]

12.3.A. Provider Referrals [Subsection Added 4/1/2025]

Eligible beneficiaries will be identified through a referral and screening process that is completed by the CMC TCM core team.

Providers knowledgeable about chronic complex physical health conditions, understand the benefits of intensive case management services, and/or have treated the beneficiary may submit referrals. The CMC TCM core team will consider referrals made by the following qualified health professionals:

- specialists/subspecialists
- emergency room physicians
- primary care physicians
- non-physician practitioners (NPPs) **(text added per bulletin MMP 24-61)**

12.3.B. Eligibility Determination [Subsection Added 4/1/2025]

Upon receipt of the referral, the CMC TCM core team confirms the beneficiary's eligibility for CMC TCM services through a review of the beneficiary's medical records and utilization data. The CMC TCM core team notifies both the referring provider and the beneficiary and/or parent/guardian of their eligibility status. Eligible beneficiaries and their parents/guardians are offered a choice to receive the CMC TCM services.

All eligibility notifications must be in writing and provide information about the beneficiary's right to appeal decisions regarding eligibility.

To assist beneficiaries and their parents/guardians in making an informed choice concerning these services, MDHHS will provide a website where interested persons can learn more about the CMC TCM program and its state-certified case management entities. **(text added per bulletin MMP 24-61)**

12.3.B.1. Primary Point of Contact and Intake Meeting [Subsection Added 4/1/2025]

Upon completion of the eligibility determination process, eligible beneficiaries will be provided a CMC TCM primary point of contact who is a member of the CMC TCM core team. The primary point of contact schedules the intake meeting with the beneficiary, the beneficiary's parents, or legal guardians. The intake meeting should be a face-to-face contact.

The purpose of the intake meeting includes, but is not limited to:

- confirming voluntary enrollment and CMC TCM case management entity selection;
- educating the beneficiary and/or parent/guardian about the CMC TCM services and answering questions;
- collecting the beneficiary's demographic and contact information, current legal status, medical and behavioral health history;
- completing needed authorizations related to the sharing of protected health information; and
- scheduling the initial in-person, comprehensive assessment with the CMC TCM core team. **(text added per bulletin MMP 24-61)**

12.3.C. Beneficiary Consent [Subsection Added 4/1/2025]

Prior to receiving the CMC TCM services, beneficiaries and/or parents/guardians must select the CMC TCM case management entity of their choice and sign the CMC TCM Informed Consent form (BPHASA-2412). The CMC TCM medical director adds their signature to the form to acknowledge that the beneficiary has been accepted and maintains the form in the beneficiary's case record.

Once accepted into the CMC TCM program, the CMC TCM core team will notify MDHHS of the new CMC TCM beneficiary by submitting a beneficiary-specific CMC TCM Authorization form (BPHASA-2409) through the Community Health Automated Medicaid Processing System (CHAMPS) Document Management Portal (DMP). Upon receipt of the BPHASA-2409, MDHHS will add the CMC TCM case management entity and their unique National Provider Identifier (NPI) number to the beneficiary's file. It is incumbent upon the CMC TCM case management entities to verify their authorization in CHAMPS prior to rendering billable services. CMC TCM case management entities who are not authorized to provide services for a beneficiary will not be eligible for CMC TCM payment. **(text added per bulletin MMP 24-61)**

12.3.D. Transfer of Care [Subsection Added 4/1/2025]

A beneficiary or parent/guardian may change CMC TCM case management entities based on beneficiary/parent/guardian preference. The current CMC TCM case management entity on record must consult with the new CMC TCM case management entity about the case and transfer all applicable information and case records, including all completed assessments and the updated comprehensive IPOC, to the new CMC TCM case management entity.

Protected health information (PHI), personally identifiable information (PII), and sensitive or confidential information should only be shared in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act (HIPAA) and the Michigan Mental Health Code, and using the most secure method and appropriate encryption standards. Only the minimum amount of PHI, PII, sensitive and/or confidential information necessary should be shared with the new CMC TCM case management entity.

To institute the change in case management entities, the current CMC TCM case management entity on record must submit a CMC TCM Deauthorization Form (BPHASA-2410) to MDHHS to request disenrollment of a CMC TCM beneficiary from their program. Then, the new CMC TCM case management entity must submit a beneficiary-specific BPHASA-2409 through the CHAMPS DMP to add the beneficiary. It is incumbent upon the new CMC TCM case management entity to verify their authorization in CHAMPS prior to rendering a CMC TCM billable service. CMC TCM case management entities who are not authorized to provide services for a beneficiary will not be eligible for CMC TCM payment. **(text added per bulletin MMP 24-61)**

12.3.E. Ongoing CMC TCM Service Participation [Subsection Added 4/1/2025]

The beneficiary's involvement in CMC TCM services is contingent upon their continued enrollment in Medicaid/CHIP and/or CSHCS. After the initial comprehensive assessment, the CMC TCM core team will offer the beneficiary and/or parent/guardian the opportunity to discuss and assess the beneficiary's continued need for intensive case management services, including: the beneficiary's needs and goals, progress and outcomes, case complexity (i.e., medical, social, psychological, and financial), support systems and resource availability, self-management capabilities, risk factors, and beneficiary's preferences. If the CMC TCM core team and beneficiary and/or parent/guardian mutually agree that the beneficiary continues to need and benefit from these services, enrollment can continue. Decisions and reasons to continue CMC TCM services should be noted in the beneficiary's case record. **(text added per bulletin MMP 24-61)**

12.3.F. CMC TCM Disenrollment [Subsection Added 4/1/2025]

CMC TCM program disenrollment is indicated if any of the following events occur:

- the beneficiary's Medicaid/CHIP and/or CSHCS enrollment ends
- the beneficiary transitions into hospice
- the beneficiary dies
- the beneficiary reaches age 21 years
- the beneficiary moves out of state
- the beneficiary chooses to opt out by:
  - requesting to end services
  - participating in a different case management program
  - failing to participate in a comprehensive assessment and/or the development of the comprehensive IPOC as requested by the CMC TCM core team
  - failing to participate in a CMC TCM billable service for a continuous period lasting more than three months
- the medical director terminates the beneficiary's participation in services for fraud, abuse, misconduct, or other reasons

If the CMC TCM core team needs to terminate CMC TCM services for any reason, the CMC TCM core team is required to notify the beneficiary and/or parent/guardian in writing 45 days before their disenrollment from the program, document the reason for the disenrollment in the beneficiary's comprehensive IPOC, offer a meeting to discuss, and advise the beneficiary of their appeal rights for any service termination.

Additionally, CMC TCM case management entities are required to submit a BPHASA-2410 to MDHHS to request the disenrollment of a CMC TCM beneficiary from the program. Forms are submitted via the CHAMPS DMP. Once services are terminated, the beneficiary will need to have their CMC TCM eligibility redetermined to resume CMC TCM services, unless otherwise approved by MDHHS. **(text added per bulletin MMP 24-61)**

12.3.G. Duplication of Services [Subsection Added 4/1/2025]

Beneficiaries must not receive case management services from more than one case management program. If, while receiving CMC TCM services, non-CMC TCM case management programs are identified as providing case management services to the CMC TCM beneficiary, the preferences of the beneficiary/parent/guardian concerning which agency provides services must be considered when roles overlap. **(text added per bulletin MMP 24-61)**

12.3.G.1. Medicaid Health Plan (MHP) Coordination [Subsection Added 4/1/2025]

The CMC TCM services are carved out of the MHP contract. CMC TCM case management entities must establish a process for the CMC TCM core team to provide written communication with MHP staff on a quarterly basis to share assessments and comprehensive IPOCs for MHP beneficiaries receiving CMC TCM services, and to ensure no service duplication occurs for mutually served beneficiaries. **(text added per bulletin MMP 24-61)**

12.4 Core Elements of CMC TCM Services [Subsection Added 4/1/2025]

CMC TCM services are intensive, comprehensive, and fully integrated case management services, designed for children with medical complexity. To achieve their intended purpose, these services must not be implemented sporadically but should be delivered consistently by staff dedicated to the program, and at a minimum every month.

CMC TCM services are multi-disciplinary, team-based services that may be accessed in multiple settings, including the clinic or home, and either in-person or via telemedicine and include:

- assessment;
- IPOC;
- referral and coordination services; and
- monitoring/follow-up activities.

CMC TCM services focus on the completion of a comprehensive assessment to identify CMC needs. The comprehensive assessment is completed by the CMC TCM core team after the CMC TCM case

management entity is added to the beneficiary's record. Guided by the outcome of this assessment, the CMC TCM core team works with the beneficiary and/or parent/guardian to develop a comprehensive IPOC that reflects the input and involvement of the beneficiary and/or parent/guardian. Ongoing care coordination, comprehensive transitional care, support, and/or referrals to medical, behavioral, school and/or community-based support services, as well as monitoring and follow-up activities, are provided through the collaborative efforts of the CMC TCM core team.

Beneficiary participation in CMC TCM is voluntary. Once enrolled, beneficiaries may opt out at any time. The beneficiary and/or parent/guardian indicates their desire to participate by signing the BPHASA-2412 and maintaining contact with and receiving services from the CMC TCM core team.

If a beneficiary and/or their parent/guardian declines CMC TCM services, the CMC TCM core team is required to document that in the beneficiary's case record. Beneficiaries who are notified of CMC TCM eligibility and choose not to receive CMC TCM services at that time may elect to receive CMC TCM services in the future if they continue to meet the eligibility criteria.

Beneficiaries may not be compelled to accept CMC TCM services. Beneficiaries who decline or choose not to receive services may do so without jeopardizing their access to other necessary medical services. If a beneficiary and/or their parent/guardian declines CMC TCM services or decides to opt out of services after services have been initiated, the CMC TCM core team is required to document that event in the beneficiary's case record.

The CMC TCM core team is required to maintain beneficiary case records for all beneficiaries who are referred to the program for CMC TCM eligibility determination. For all enrolled beneficiaries, the CMC TCM core team must document the date of all contacts in the beneficiary's case record. Specifically, the case record must include the following information:

- The name of the individual;
- The dates of the case management services;
- The name of the case management entity (if relevant) and the person providing the case management service;
- The nature and content of the case management services provided and whether goals specified in the IPOC have been achieved;
- Whether the individual had declined services in the IPOC;
- The need for, and occurrences of, coordination with other case managers;
- A timeline for obtaining needed services; and
- A timeline for reevaluation of the IPOC. **(text added per bulletin MMP 24-61)**

12.4.A. Comprehensive Assessment [Subsection Added 4/1/2025]

Case management services include a comprehensive assessment to determine the beneficiary's need for medical, educational, social, and/or other services. The assessment must be a written document. Comprehensive assessments are covered no more than once per year from the date of the initial comprehensive assessment, unless otherwise approved by MDHHS.

The entire CMC TCM core team assigned to the beneficiary is required to be part of the initial, comprehensive assessment with the beneficiary and/or parent/guardian. The initial comprehensive assessment is conducted as an in-person encounter with at least two members of the core team present in-person. Subsequent comprehensive assessments can be conducted face-to-face. The purpose of the comprehensive assessment is to gather sufficient information to develop a comprehensive IPOC for the beneficiary. **(text added per bulletin MMP 24-61)**

12.4.B. COMPREHENSIVE INDIVIDUALIZED PLAN OF CARE (IPOC) DEVELOPMENT [SUBSECTION ADDED 4/1/2025]

The CMC TCM core team must develop and document a comprehensive IPOC based on the information collected from the comprehensive assessment. At a minimum, the IPOC must:

- specify goals and objectives that address the medical, social, educational and any other identified needs, including social determinants of health;
- identify a course of action to respond to the beneficiary's assessed needs;
- include the duration, scope, and amount of services needed, as well as identify the service provider and timeframes for initiating and/or completing the identified actions;
- describe the responsibilities of the beneficiary/parent/guardian associated with accomplishing the comprehensive IPOC; and
- at least quarterly, document progress toward achieving specified goals and objectives.

The CMC TCM core team must work with the beneficiary and/or their parent/guardian to develop the IPOC's goals/objectives and to identify a course of action to respond to the beneficiary's assessed needs. The comprehensive IPOC should address the physical and behavioral health needs of the beneficiary, along with any other needed resources such as housing, energy assistance, food and nutrition, vocational training, cultural and spiritual needs, and transportation needs. The IPOC should also address emergency situations and/or determine the steps to take during the exacerbation of symptoms.

Development of the comprehensive IPOC with the beneficiary/parent/guardian is conducted as a face-to-face encounter. To the maximum extent possible, the CMC TCM core team is required to ensure that the beneficiary and/or parent/guardian are actively involved in the development of the IPOC.

The CMC TCM core team should share the IPOC with the beneficiary/parent/guardian, and others, including medical and social service providers, as applicable and allowable. At a minimum, the comprehensive IPOC must be reviewed and/or updated quarterly depending on the needs of the beneficiary. Periodic reviews and updates of the IPOC are covered as monitoring and follow-up activities. **(text added per bulletin MMP 24-61)**

12.4.C. REFERRALS AND CARE COORDINATION SERVICES [SUBSECTION ADDED 4/1/2025]

Working collaboratively with the beneficiary/parent/guardian, their specialists/subspecialists, and their primary care and/or other health care providers,

members of the CMC TCM core team will facilitate and coordinate the services detailed in the comprehensive IPOC. The CMC TCM core team will also assist with referrals and other related activities to support the beneficiary in obtaining needed services. Ongoing referral and service coordination activities include face-to-face and/or reciprocal telephonic or written contacts with, or on behalf of, the beneficiary/parent/guardian. **(text added per bulletin MMP 24-61)**

12.4.D. Monitoring and Follow-Up Activities [Subsection Added 4/1/2025]

Monitoring and follow-up activities include actions and contacts necessary to ensure the comprehensive IPOC adequately addresses the beneficiary's needs and is implemented. Monitoring activities may be conducted with the beneficiary/parent/guardian, service providers, or other entities. These activities also include ensuring that changes in the needs or status of the beneficiary are reflected in the IPOC, and that the beneficiary can access services contained in the IPOC and/or is receiving these services.

Monitoring and follow-up activities include face-to face encounters and/or reciprocal telephonic or written contact with, or on behalf of, the beneficiary/parent/guardian. Telemedicine encounters may be provided at the discretion of the beneficiary and/or the beneficiary's parents/guardians. **(text added per bulletin MMP 24-61)**

12.4.D.1. Frequency of Monitoring and Follow-Up Activities [Subsection Added 4/1/2025]

Monitoring shall occur monthly, or more often if needed, to ensure the beneficiary's needs are met and to maintain a continuing relationship between the beneficiary, their parent/guardian, and any providers responsible for services. Frequency and scope of case management monitoring and follow-up activities must reflect the intensity of the beneficiary's physical health, behavioral health, and welfare needs identified in the comprehensive IPOC. The CMC TCM core team is required to discuss and document the proposed frequency of contacts with the beneficiary and/or their parent/guardian. The discussion must include the frequency of contacts with the beneficiary, any providers instrumental to the implementation of the IPOC, and any other individuals directly related to implementing services and supports on behalf of the beneficiary.

If the frequency of contacts is less than a monthly, reciprocal encounter, the CMC TCM core team documents the reason in the beneficiary's case record. **(text added per bulletin MMP 24-61)**

12.4.E. Service Availability and Accessibility [Subsection Added 4/1/2025]

A CMC TCM core team member must be available and accessible 24 hours per day to a beneficiary and/or their parent/guardian. **(text added per bulletin MMP 24-61)**

12.4.F. Types of Encounters [Subsection Added 4/1/2025]

The initial comprehensive assessment is conducted as an in-person encounter with the beneficiary, parent/guardian, and the entire team assigned to the beneficiary. Upon completion of the initial assessment, the beneficiary must be seen in-person at least once per year. This encounter can occur during any of the CMC TCM core services

administered by members of the CMC TCM core team assigned to the beneficiary. Subsequent comprehensive assessments and IPOC development encounters must be face-to-face and involve CMC TCM core team members assigned to the beneficiary. Referrals and service coordination services and monitoring and follow-up activities can include face-to face encounters and/or reciprocal telephonic or written contact with, or on behalf of, the beneficiary/parent/guardian conducted by any member of the CMC TCM core team. **(text added per bulletin MMP 24-61)**

12.4.G. Excluded Services [Subsection Added 4/1/2025]

CMC TCM does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which a beneficiary has been referred. Furthermore, case management services do not include activities that are an integral and inseparable component of another Medicaid-covered service.

Medical services provided by the CMC TCM core team members must be within their scope of practice, in consultation with the beneficiary's specialist(s), and at the request of the beneficiary and/or their parent/guardian. Allowable medical services are billed separately and in accordance with established Medicaid policy. **(text added per bulletin MMP 24-61)**

12.5 CMC TCM Case Management Qualifications [Subsection Added 4/1/2025]

The CMC TCM case management entity must be enrolled in Michigan Medicaid and demonstrate their willingness and qualifications to provide the CMC TCM services, as described herein. All case management entities must be certified by MDHHS prior to providing CMC TCM services. Additionally, the approved CMC TCM case management entity must obtain a separate NPI number that will be used when submitting claims specifically for CMC TCM services.

CMC TCM case management entities will be required to complete a CMC TCM Program Application form (BPHASA-2411). By signing and submitting the BPHASA-2411, the CMC TCM case management entity attests they are able to meet both the CMC TCM case management entity and core team requirements and adhere to this policy, the State Plan, and other applicable MDHHS policies and procedures. A CMC TCM case management entity is designated as a service provider only after MDHHS receives and certifies the signed attestation. (Refer to the Provider Enrollment Section of the General Information for Providers chapter within the MDHHS Medicaid Provider Manual for additional enrollment information). **(text added per bulletin MMP 24-61)**

12.5.A. CMC TCM Core Team [Subsection Added 4/1/2025]

Case management services must be provided by a multi-disciplinary team working under the authority of a CMC TCM case management entity that consists of licensed and unlicensed staff and licensed health professionals operating within their state law defined scope of practice. Teams must have adequate knowledge and experience to provide comprehensive and specialized case management services to children with very complex medical needs. Required CMC TCM core team members are as listed and include the following:

- pediatrician (Medical Director);

- non-physician practitioner (NPP);
- registered nurse (RN);
- licensed clinical social worker (LCSW);
- program coordinator; and
- administrative staff.

A licensed pediatric behavioral health provider is recommended to be part of the CMC TCM core team as the CMC TCM core team identifies and is required to provide case management for all needs, including psychosocial needs. Additional team members may be added to consult regarding specific health concerns (i.e., dietician, respiratory and other therapists, etc.).

Qualifications of individual CMC TCM core team members, with dedicated time to the program, are as listed:

- At least one provider with medical/surgical experience with delivering pediatric hospital or specialty clinic services to medically complex individuals under the age of 21 who regularly experience hospitalization and/or surgery;
- At least one Medicaid-enrolled, licensed pediatrician in possession of or eligible for pediatric specialty board certification. Experience and/or training in palliative care recommended;
- At least one Medicaid-enrolled, licensed NPP with at least two years of professional pediatric experience. A NPP is a healthcare professional licensed as a nurse practitioner, physician assistant, or a clinical nurse specialist;
- At least one licensed master's prepared Clinical Social Worker with at least two years of professional pediatric experience;
- At least one licensed RN with at least two years of professional pediatric experience;
- At least one individual with a Bachelor of Arts or Science in an academic, business, or medical discipline with experience as a hospital or clinic coordinator with a background in health care who is knowledgeable about case management or care coordination services for individuals with very complex health needs who have hospital admissions or have had/need surgery; and
- A program assistant with a background in health care operations, referrals, scheduling, and patient services.

Additionally, the CMC TCM core team is required to have:

- the ability to support full integration of psychosocial and clinical care;
- sufficient documentation that demonstrates staff has adequate knowledge and experience to provide comprehensive and intensive case management services to beneficiaries with very complex medical and psychosocial needs;
- referral and/or effective working relationships with specialists/subspecialists and other key health care and social service providers who are essential to the care of beneficiaries

with complex medical and psychosocial needs (e.g., primary care, private duty nurses, and state and community-based organizations); and

- 24/7 on-call coverage to respond to medical and care coordination needs.

CMC TCM case management entities must enroll through the online MDHHS CHAMPS' Provider Enrollment (PE) subsystem to be reimbursed for fees for services rendered to beneficiaries.

CMC TCM core team members, whose services are directly reimbursable per MDHHS policy, must be separately enrolled in CHAMPS and authorized and approved to bill for services. **(text added per bulletin MMP 24-61)**

12.5.B. Telemedicine [Subsection Added 4/1/2025]

Services specified as "face-to-face" per MDHHS telemedicine policy can either be performed in-person or via simultaneous audio/visual telemedicine. CMC TCM case management entities are required to follow Medicaid telemedicine policy requirements, as applicable. (Refer to the Telemedicine chapter of the MDHHS Medicaid Provider Manual.) **(text added per bulletin MMP 24-61)**

12.6 Reporting Requirements [Subsection Added 4/1/2025]

12.6.A. CMC TCM Case Management Entity Reporting [Subsection Added 4/1/2025]

CMC TCM case management entities are responsible for reporting encounter, clinical outcomes, quality, cost, and other data as requested by MDHHS and/or its designee. MDHHS will require the CMC TCM case management entity to collect, maintain, and organize CMC TCM reporting data. MDHHS will also require the CMC TCM case management entity to send all requested reports to MDHHS in accordance with state defined timelines.

Additionally, CMC TCM case management entities may be requested to submit staffing reports, participate in site visits/audits, and assist in facilitating annual patient experience surveys. CMC TCM case management entities are required to respond to data requests as a condition of continued participation as a CMC TCM program. To the extent possible, MDHHS paid claims data will be utilized for monitoring and evaluation and MDHHS will rely on the CMC TCM case management entity for data not available through the claims system. **(text added per bulletin MMP 24-61)**

12.7 Claims Submission [Subsection Added 4/1/2025]

CMC TCM claims are billed according to instructions contained in the Billing & Reimbursement for Professionals Chapter of the MDHHS Medicaid Provider Manual. CMC TCM claims adhere to the Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ASC X12N version 5010 information. CMC TCM claims must be submitted under the CMC TCM services unique NPI number. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing, and referring providers as applicable for payment.

Medicaid reimbursement for CMC TCM services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

CMC TCM services are carved out of the MHPs and are billed and reimbursed as a FFS benefit. All providers submitting claims for services must be Medicaid-enrolled. (Refer to the Billing & Reimbursement for Professionals chapter and the Billing & Reimbursement for Institutional Providers chapter of the MDHHS Medicaid Provider Manual for additional billing information.) **(text added per bulletin MMP 24-61)**

12.7.A. Allowable Procedure Codes [Subsection Added 4/1/2025]

All claims submitted for CMC TCM services provided to beneficiaries must include the following Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- G0506 – Comprehensive assessment and care planning for patients requiring chronic case management services. This code must be used when billing the comprehensive assessment and comprehensive IPOC services. This code is limited to one unit of service each year, per CMC TCM case management entity, per beneficiary, unless otherwise approved by MDHHS. This code is not reimbursable for dates of service (DOS) in the same calendar month for the same CMC TCM case management entity and beneficiary as T2023.

  Case management entities receive a flat fee per beneficiary for the completion of a comprehensive assessment and comprehensive IPOC that meets the coverage criteria. The rate of reimbursement for comprehensive assessment and care planning (G0506) under the CMC TCM program can be found on the Children's Special Health Care Services (CSHCS) webpage of the MDHHS website. (Refer to the Directory Appendix for website information.)
- T2023 – Targeted case management per month. This code must be used to bill ongoing referral and care coordination services and monitoring and follow-up activities. This code is limited to one unit of service per calendar month, per CMC TCM case management entity, per beneficiary. This code is not reimbursable for DOS in the same calendar month for the same CMC TCM case management entity and beneficiary as G0506.

Ongoing referral and care coordination services and monitoring and follow-up activities are reimbursable for beneficiaries who have a completed comprehensive assessment and comprehensive IPOC. Periodic reassessments, reviews, and updates of the IPOC are reimbursable as part of the monitoring and follow-up activities.

Services are reimbursable only if a member of the CMC TCM core team has at least one face-to-face or reciprocal contact with the beneficiary and/or their parent/guardian during the billable month. The rate of reimbursement for targeted case management per month (T2023) under the CMC TCM program can be found on the Children's Special Health Care Services (CSHCS) webpage of the MDHHS website. (Refer to the Directory Appendix for website information.) **(text added per bulletin MMP 24-61)**

12.7.B. Date of Service (DOS) [Subsection Added 4/1/2025]

Case management entities should adhere to the following guidelines when determining the DOS:

- For activities related to the comprehensive assessment and comprehensive IPOC development (indicated by HCPCS procedure code G0506), the DOS is the date the IPOC is completed.
- For activities related to ongoing referral and coordination services and monitoring and follow-up activities (indicated by HCPCS procedure code T2023), indicate the last day of the month as the DOS on the claim form. The actual DOS for each case management service provided must be documented in the beneficiary's case record. **(text added per bulletin MMP 24-61)**

12.7.C. Place of Service (POS) [Subsection Added 4/1/2025]

Case management entities should use a valid place of service (POS) code to indicate the setting in which services were provided. If services occurred in multiple settings, case management entities may bill using the most frequently occurring POS code; however, the actual POS must be indicated when documenting each case management activity in the beneficiary's case record. **(text added per bulletin MMP 24-61)**

12.7.D. Third Party Liability [Subsection Added 4/1/2025]

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the CMC TCM case management entity does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter of the MDHHS Medicaid Provider Manual for additional information.) **(text added per bulletin MMP 24-61)**

TELEMEDICINE

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SECTION 1 – GENERAL TELEMEDICINE POLICY

1.1 GENERAL INFORMATION

Telemedicine is the use of telecommunication technology to connect a beneficiary with a Medicaid enrolled health care professional in a different location. The Michigan Department of Health and Human Services (MDHHS) covers both synchronous (real-time interactions) and asynchronous (over separate periods of time) telemedicine services. MDHHS requires that all telemedicine policy provisions within this policy and other current policy are established and maintained within all telemedicine services.

Along with general telemedicine policy, specific program considerations (as listed within this chapter) must be upheld during all telemedicine visits unless otherwise stated. The specific program section provides additional requirements and offers further clarification as needed. These should always be considered in combination with all general telemedicine policy.

1.2 MDHHS DEFINITION OF TELEMEDICINE

MDHHS aligns the definition of telemedicine with Section 3476 of the Insurance Code of 1956, 1956 PA 218 MCL 500.3476, as updated on December 20, 2017. Therefore, "Telemedicine" means the use of an electronic media to link beneficiaries with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the beneficiary via a real-time, interactive audio or video (or both) telecommunications system, and the beneficiary must be able to interact with the off-site health care professional at the time the services are provided.

1.3 AUTHORIZED PROVIDERS

In alignment with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in their health care profession in the state where the beneficiary is located. The provider at the distant site who is licensed under State law to furnish a covered telemedicine service (as described in telemedicine policy) may bill, and receive payment for, the service when it is delivered via a telecommunications system.

Telemedicine providers must be enrolled in Michigan Medicaid and must have the ability to refer the beneficiary to another provider of the same type or specialty who can see the beneficiary in-person when necessary. If rendering services within a managed care plan, providers must refer beneficiaries to resources within the plan for additional services as needed.

1.3.A. OUT-OF-STATE/BEYOND BORDERLAND PROVIDERS

Michigan Medicaid telemedicine policy permits providers who are licensed in another state to render/be reimbursed for telemedicine services for Michigan Medicaid-enrolled beneficiaries if the beneficiary is in the state where the provider is licensed.

Unless otherwise specified in policy, telemedicine providers associated to a billing provider located outside of Michigan must obtain prior authorization (PA) for services.

Providers should refer to the Out-of-State/Beyond Borderland Providers subsection in the General Information for Providers chapter for situations where PA could be approved.

Refer to the PSYPACT subsection for specific situations where an out-of-state licensed provider is otherwise authorized to render/be reimbursed for telemedicine services.

1.3.B. Virtual-Only Providers

Telemedicine providers who do not have a physical location for treatment, but are Michigan licensed and meet all other Medicaid enrollment requirements, are considered "virtual-only" and are permitted to render services for Michigan Medicaid-enrolled beneficiaries.

Virtual-only providers not associated to a Michigan billing provider within the Community Health Automated Medicaid Processing System (CHAMPS) will be subject to out-of-state provider PA requirements. Providers should refer to the Out-of-State/Beyond Borderland Providers subsection in the General Information for Providers chapter for situations where PA could be approved.

Virtual-only providers must report Place of Service (POS) 02 or 10 along with the appropriate modifier when submitting claims/encounters for telemedicine.

1.3.C. PSYPACT

Telemedicine providers who have an Authority to Practice Interjurisdictional Telepsychology (APIT) certificate from the Psychology Interjurisdictional Compact (PSYPACT) Commission are eligible to render/be reimbursed for telemedicine services for Medicaid beneficiaries as authorized under PSYPACT and allowed by Medicaid telemedicine policy.

PSYPACT providers must abide by the same telemedicine requirements as all other telemedicine providers. Services performed by PSYPACT providers are subject to PA requirements that would apply if the provider were located in-state. Providers should refer to the CHAMPS Code Rate and Reference tool for service-specific in-state authorization requirements.

PSYPACT providers must report POS 02 or 10 along with the appropriate modifier when submitting claims/encounters for telemedicine.

1.4 Principles of Telemedicine

Recognizing that telemedicine can never fully replace in-person care, MDHHS has established the following principles to be used by MDHHS-enrolled providers during the provision of telemedicine services:

- Effectual services – a service provided via telemedicine should be as effective as its in-person equivalent, ensuring convenient and high-quality care.

- Improved and appropriate access – the right visit, for the right beneficiary, at the right time by minimizing the impact of barriers to care, such as transportation needs or availability of specialty providers in rural areas.
- Appropriate beneficiary choice – the beneficiary is an active participant in the decision for telemedicine as a means for service delivery as appropriate (e.g., Does the beneficiary prefer telemedicine to an in-person visit? What is the optimal combination of ongoing service delivery for the individual? etc.).
- Appropriate utilization – ensure providers are utilizing telemedicine appropriately and that items listed above are taken into consideration when offering these services.
- Value considerations – telemedicine visits should yield the desired outcomes and quality measures; health outcomes should be improving and remain consistent with in-person care at a minimum.
- Privacy and security measures – providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy/security regulations as applicable.

1.5 Determination of Appropriateness/Documentation

Telemedicine must only be utilized when there is a clinical benefit to the beneficiary. Examples of clinical benefit include:

- Ability to diagnose a medical condition in a beneficiary population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a beneficiary population without access to clinically appropriate in-person treatment options.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or another quantifiable symptom.

Furthermore, telemedicine must only be utilized when the beneficiary's goals for the visit can be adequately accomplished, there exists reasonable certainty of the beneficiary's ability to effectively utilize the technology, and the beneficiary's comfort with the nature of the visit is ensured. Telemedicine must be used as appropriate regarding the best interests/preferences of the beneficiary and not merely for provider ease. Appropriate guidance must be provided to the beneficiary to ensure they are prepared and understand all steps to effectively utilize the technology prior to the first visit. Beneficiary consent must be obtained prior to service provision (see policy for "Consent for Telemedicine Services" for further information).

In-person visits remain the preferred method of service delivery for most healthcare services; however, in cases where this option is not available or in-person services are not ideal or are challenging for the beneficiary, telemedicine may be used as a complement to in-person services. Applicable beneficiary

records must contain documentation regarding the reason for the use of telemedicine and the steps taken to ensure the beneficiary was provided utilization guidance in an appropriate manner.

In special situations, depending upon the needs of the beneficiary, providers may opt to deliver the majority of or all services for a specific condition via telemedicine. If this situation occurs, it must be documented in the beneficiary's record or in their individual plan of service (IPOS). This situation should be the exception, not the norm. (Refer to the program-specific subsections of this policy for specific guidance regarding this benefit.)

All services provided via telemedicine must meet all the quality and specifications as would be if performed in-person. Furthermore, if while participating in the visit the desired goals of the beneficiary and/or the provider are not being accomplished, either party must be provided the opportunity to stop the visit and schedule an in-person visit instead (refer to "Contingency Planning" for such instances). This follow-up visit must be provided within a reasonable time and be as easy as possible to schedule.

1.6 Consent for Telemedicine Services

MDHHS requires either direct or indirect beneficiary consent for all services provided via telemedicine. This consent must be properly documented in the beneficiary's medical record in accordance with applicable standards of practice. This requirement aligns with Section 16284 of State of Michigan Public Act No. 359, effective March 29, 2017.

1.7 Privacy and Security Requirements

MDHHS requires a HIPAA compliant real-time interactive system at both the originating and distant sites, allowing instantaneous interaction between the beneficiary and provider via the telecommunication system. When providing services via telemedicine, sufficient privacy and security measures must be in place and documented to ensure confidentiality and integrity of beneficiary-identifiable information. This includes, but is not limited to, ensuring any tracking technologies used by websites, mobile applications, or any other technology used comply with applicable law regarding use or disclosure of beneficiary-identifiable information. Transactions, including beneficiary email, prescriptions, and laboratory results, must be secure within existing technology (i.e., password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All beneficiary-provider email, as well as other beneficiary-related electronic communications, should be stored and filed in the beneficiary's medical record consistent with transitional recordkeeping policies and procedures.

1.8 Contingency Planning

A contingency plan, including referral to an acute care facility or Emergency Room (ER) for treatment as necessary for the safety of the beneficiary, is required when utilizing telemedicine technologies. This plan must include a formal protocol appropriate to the services being rendered.

1.9 Prior Authorization Requirements

There are no prior authorization (PA) requirements when providing services via telemedicine for Fee-for-Service (FFS) beneficiaries or for those accessing Behavioral Health Services through PIHPs/CMHSPs unless the equivalent in-person service requires PA. Authorization requirements for beneficiaries enrolled in Medicaid Health Plans (MHPs) may vary. Providers must refer to individual MHPs for any authorization or coverage requirement.

1.10 Face-to-Face Definition

When referenced within MDHHS Telemedicine Policy, face-to-face refers to either an in-person visit or a visit performed via simultaneous audio/visual technology.

1.11 Originating Site

Originating site is defined as the location of the eligible beneficiary at the time of the telemedicine service.

Authorized originating sites include:

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center (FQHC)
- Hospital (inpatient, outpatient, or critical access hospital)
- Office of a physician or other provider (including medical clinics)
- Hospital-based or Critical Access Hospital (CAH)-based Renal Dialysis Centers (including satellites)
- Rural Health Clinic (RHC)
- Skilled nursing facility
- Tribal Health Center (THC)
- Local Health Department (LHD) as defined in Sections 333.2413, 333.2415 and 333.2421 of the Michigan Public Health Code (PA 368 of 1978 as amended)
- Home, as defined as a location, other than a hospital or other facility, where the beneficiary receives care in a private residence
- Other established site considered appropriate by the provider (in accordance with clinical judgement)

1.12 Distant Site

Distant site is defined as the location of the provider providing the professional service at the time of the telemedicine visit. This definition encompasses the provider's office, or any established site considered appropriate by the provider, so long as the privacy of the beneficiary and security of the information shared during the telemedicine visit are maintained.

1.13 Audio-Only Telemedicine

MDHHS supports the use of simultaneous audio/visual telemedicine service delivery as a primary method of telemedicine service; however, in situations where the beneficiary cannot access services via a simultaneous audio/visual platform, either due to technology constraints or other concerns, MDHHS will allow the provision of audio-only services for a specific set of procedure codes.

Additional guidelines for audio-only service include:

- Visits that include an assessment tool -- the tool must be made available to the beneficiary and the provider must ensure the beneficiary can access the tool.
- When a treatment technique or evidence-based practice requires visualization of the beneficiary, it must be performed via simultaneous audio/visual technology.
- Audio-only must be performed at the preference of the beneficiary, not the provider's convenience.
- Privacy and security of beneficiary information must always be established and maintained during an audio-only visit.

To effectuate this in perpetuity, MDHHS will publish audio-only databases that will include all codes MDHHS is permitting via audio-only. These databases will be created for both FFS/MHP providers and for those providers within the PIHP/CMHSP system and will be maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) MDHHS will, on a regular and ongoing basis, assess the audio-only databases and will add/remove codes as needed. Some of the criteria used to determine addition/removal from the audio-only database include provider/stakeholder feedback, new coding guidelines, utilization data and quality reports.

1.14 Asynchronous Telemedicine Services

Asynchronous telemedicine services include the transmission of a beneficiary's medical or other personally identifiable information through a secure, HIPAA-compliant, electronic communications system to a provider, often a specialist, at a distant site without the beneficiary present. Such communications, including store and forward services, interprofessional telephone/Internet/electronic health record consultations, and remote patient monitoring (RPM) services, involve contact between two parties (beneficiary to provider or provider to provider) in a way that does not require real-time interaction. Services must be medically necessary or essential for behavioral health and part of a provider-directed treatment plan.

Asynchronous telemedicine services must be performed under the general or direct supervision of a Medicaid-enrolled physician or practitioner who has an active role in the management of the beneficiary's physical and/or behavioral health. The analysis and interpretation of the beneficiary's data must contribute to the development and/or monitoring of the beneficiary's treatment plan. Asynchronous telemedicine services do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the beneficiary. Photographs visualized by a telecommunications system must be specific to the beneficiary's physical and/or behavioral health condition and adequate for furnishing or confirming a diagnosis and/or treatment plan.

Asynchronous telemedicine services generally may not be separately reported on the same day the beneficiary presents for an evaluation and management (E/M) or other related service to the same provider. These services are typically considered part of the E/M or other related service and are not separately reimbursed. Activities performed in the facility setting under the general or direct supervision of the provider are bundled with the facility services on the UB-04 claim form and cannot be reported on the CMS 1500 claim form or billed under the provider's National Provider Identifier (NPI). Refer to the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS) for service code parameters and limits.

In accordance with Section 16284 of Public Act No. 359 of 2016, telemedicine services, including asynchronous telemedicine, must be provided only with direct or indirect beneficiary consent and this consent must be properly documented in the beneficiary's medical record in accordance with applicable standards of practice.

1.14.A. Store and Forward Services

Store and forward services are asynchronous electronic transmissions of physical and/or behavioral health information from the beneficiary to a Medicaid-enrolled physician or practitioner at the distant site when video or face-to-face contact is not necessary. Information transmitted to the provider is analyzed and used in the diagnosis, development, or maintenance of an individualized treatment plan. Information may include, but is not limited to, digital images, documents, video clips, still images, x-rays, magnetic resonance images (MRIs), electrocardiograms (EKGs) and electroencephalograms (EEGs), and audio clips.

Store and forward services include interpretation and follow-up with the beneficiary. Services must not originate from or result in a related E/M service.

1.14.B. Interprofessional Telephone/Internet/Electronic Health Record Consultations

Interprofessional consultations (including e-Consults) are defined as a type of asynchronous telemedicine service in which the beneficiary's Medicaid-enrolled treating provider (e.g., attending or primary) requests the opinion and/or treatment advice of a Medicaid enrolled consulting provider with the specialty expertise to assist in the diagnosis and/or management of the beneficiary's condition without beneficiary face-to-face contact with the consulting provider. The service must be for the direct benefit of the beneficiary, directly relevant to the individual beneficiary's original evaluation, diagnosis, and/or treatment, and must conclude with a written report from the consulting provider to the treating provider, when applicable.

The beneficiary for whom the service is requested may be either a new or established patient to the consulting provider. Service time is based on the total review and interprofessional communication time. The review of beneficiary information, including but not limited to medical records, laboratory studies, imaging studies, medications, and pathology reports, is included in the service and should not be separately reported. The written or verbal request for the consultation must be documented in the beneficiary's medical record by the treating provider. Additional documentation requirements (within the medical record of the beneficiary) include date of service; name of provider agency or person providing the service; nature, extent, or units of service; and the place of service, along with all record keeping requirements as outlined in the MDHHS Medicaid Provider Manual. Providers must also consult with the American Medical Association (AMA) coding guidelines to ensure appropriate reporting of these services. Providers should not report interprofessional telephone/Internet/electronic health record consultations when the sole purpose of the communication is to arrange a transfer of care or other face-to-face service. In consultations that cross state lines, consulting providers must be an enrolled Medicaid provider in the state in which the beneficiary resides, though they need only be licensed/credentialed in the state in which they are

practicing. Interprofessional consultations that occur across state lines require prior authorization. Refer to the General Information for Providers chapter for further information regarding out-of-state/beyond borderland providers and the prior authorization process.

1.14.C. Remote Patient Monitoring (RPM)

Remote Patient Monitoring (RPM) is a covered service under Michigan Compiled Law (MCL) 400.105g. RPM means using digital technology to collect medical and other forms of health data from an individual in one location and electronically transmit that information via a secure, HIPAA-compliant system to a provider in a different location for assessment and recommendations. RPM is covered for both acute and chronic conditions.

RPM devices include (1) non-invasive remote monitoring devices that measure or detect common physiological parameters and (2) non-invasive monitoring devices that wirelessly transmit the beneficiary's medical information to their health care provider or other monitoring entity. The device must be reliable and valid, and the beneficiary must be trained or sufficiently knowledgeable in the proper use/wearing of the device to ensure appropriate recording of medical information. Medical information may include, but is not limited to, blood pressure and heart rate and rhythm monitoring.

All RPM devices, including mobile medical applications, must meet the U.S. Food & Drug Administration (FDA) definition of a medical device. Personal tablets, computers, cell phones, software intended for administrative support or support of healthy lifestyles/general wellness, and electronic health records are not medical devices or durable medical equipment and are not covered as part of RPM services.

Reimbursement for the device used for remote monitoring, and programming of the device, is generally included in the reimbursement of RPM services and not separately reimbursable. For items or devices separately reimbursed to a medical supplier, such as personal use continuous glucose monitoring systems (CGMs), refer to the Medical Supplier chapter of this Manual.

1.15 Telemedicine Reimbursement Rate

The reimbursement rate for allowable telemedicine services will be the same (also known as "at parity") as in-person services. This means that all providers will be paid the equivalent amount, no matter the physical location of the beneficiary during the visit. To effectuate this policy, the provider must report the place of service as they would if they were providing the service in-person. See the "Telemedicine Billing Requirements" section of this policy for further details.

1.16 Telemedicine Billing Requirements

All telemedicine visits are required to ascribe to correct coding requirements equivalent to in-person services, including ensuring that all aspects of the code billed are performed during the visit.

1.16.A. Allowable Services

Allowable telemedicine services for synchronous telemedicine are listed on the telemedicine fee schedules which can be accessed on the MDHHS website.

Asynchronous telemedicine service codes are listed on the corresponding provider-specific fee schedules. Additional program-specific coverage will be represented on individual program fee schedules and will be indicated in the program-specific sections below as indicated.

For End Stage Renal Disease (ESRD), MDHHS aligns with Medicare policy regarding the delivery of telemedicine and frequency of in-person services.

For PIHP/CMHSP service providers where in-person visits are required, the telemedicine service may be used in addition to the required in-person visit but cannot be used as a substitute. Refer to the MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database for services allowed via telemedicine. (Refer to the Directory Appendix for website information.)

1.16.B. Telehealth Facility Fee

Allowable originating sites are permitted to submit claims for the telehealth facility fee. This fee is intended to reimburse the provider for the expense of hosting the beneficiary at their location. To submit this code, the originating site must ensure the technology is functioning, the privacy of the beneficiary is secured, and that the information is shared confidentially.

Telemedicine services where "home" or another "established site considered appropriate by the provider" are utilized as the originating site are not eligible to receive the telehealth facility fee. Distant site providers in these situations are instructed to bill the appropriate Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code (as represented by the Telemedicine database) for the service(s) provided.

Neither the originating site nor the distant site is permitted to bill **both** the telehealth facility fee and the code for the professional service for the same beneficiary at the same time.

1.16.C. Place of Service (POS), Modifier 95 and Modifier 93

All audio/visual telemedicine services, as allowable on the Telemedicine fee schedule and submitted on the professional invoice, must be reported with the Place of Service (POS) code that would be reported as if the beneficiary were in-person for the visit along with modifier 95—"Synchronous Telemedicine Service rendered via a real-time interactive audio and video telecommunications system".

All audio-only telemedicine services, as represented on the audio-only telemedicine fee schedule and submitted on the professional invoice, must be reported with the POS code that would be reported as if the beneficiary were in-person for the visit along with

modifier 93 - "Synchronous Telemedicine Service rendered via telephone or other real-time interactive audio-only telecommunications system".

For services submitted on the institutional invoice, the appropriate National Uniform Billing Committee (NUBC) revenue code, along with the appropriate telemedicine CPT/HCPCS procedure code and modifier 95 or modifier 93, must be used.

PIHP/CMHSP providers must submit encounters for audio/visual telemedicine with POS 02 or 10 (as applicable) and for audio-only POS 02 or 10 (as applicable) and Modifier 93.

Covered asynchronous telemedicine services must be billed with applicable POS and modifiers as standard practice.

For PIHP/CMHSP service providers, refer to the MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database and the Audio-Only Telemedicine Database on the MDHHS website for services allowed via both audio/visual and audio-only telemedicine.

This information should be used in conjunction with the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters as well as the Medicaid Code and Rate Reference tool and other related procedure databases/fee schedules located on the MDHHS website.

SECTION 2 – SPECIFIC PROGRAM/SERVICE SITE CONSIDERATIONS

2.1 OUTPATIENT HOSPITAL

When the outpatient facility provides administrative support for a telemedicine service, the outpatient hospital facility may bill the hospital outpatient clinic visit on the institutional claim with modifier 95 or modifier 93 and the appropriate revenue code.

2.2 BEHAVIORAL HEALTH

2.2.A. PIHP/CMHSP

The MDHHS Bureau of Specialty Behavioral Health Services requires all the requirements of Telemedicine policy are attained and maintained during all beneficiary visits. In addition to the Determination of Appropriateness/Documentation section of this policy, the Bureau of Specialty Behavioral Health Services would like to reiterate that services delivered to the beneficiary via telemedicine be done at the convenience of the beneficiary, not the convenience of the provider. In addition, these services must be a part of the person-centered plan of service and available as a choice, not a requirement, to the beneficiary.

Telemedicine providers who are rendering services within the specialty behavioral health system must follow all PIHP/CMHSP enrollment procedures. These PIHP/CMHSP providers are required to be affiliated to the beneficiary's care team (via a shared medical record or a referral relationship) to ensure that the beneficiary has reasonably frequent and periodic in-person evaluations to personally reassess and update the beneficiary's medical treatment/history, effectiveness of treatment modalities, and current medical/behavioral condition and/or treatment plan.

If the individual (beneficiary) is not able to communicate effectively or independently, they must be provided appropriate on-site support from natural supports or staff. This includes the appropriate support necessary to participate in assessments, services, and treatment.

The PIHP/CMHSP must guarantee the individual is not being influenced or prompted by others when utilizing telemedicine.

Use of telemedicine should ensure and promote community integration and prevent isolation of the beneficiary. Evidence-based practice policies must be followed as appropriate for all services. For services within the community, in-person interactions must be prioritized.

2.2.A.1. REQUIREMENTS FOR VISIT

Telemedicine is allowed for all services indicated in the Bureau of Specialty Behavioral Health Services Telemedicine Database. The features of what will be counted as a telemedicine visit need to align with the same standards of an in-person visit. Any phone call or web platform used to schedule, obtain basic information or miscellaneous work that would have been billed as a non-face-to-face and therefore non-billable contact, will

remain non-billable. Telemedicine visits must include service provision as indicated in the IPOS and should reflect work towards or review of goals and objectives indicated forthwith.

2.2.A.2. POPULATIONS

This policy applies to all populations served within PIHPs/CMHSPs and does not supersede any federal regulations that must be followed for substance use disorder (SUD) treatment.

2.2.B. OUTPATIENT MENTAL HEALTH SERVICES PROVIDERS

Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs may receive outpatient mental health services through Medicaid FFS or MHPs as applicable. These FFS/MHP enrolled non-physician behavioral health services may be provided via telemedicine when performed by Medicaid-enrolled psychologists, social workers, counselors, and marriage and family therapists. Services are covered when performed in a non-facility setting or outpatient hospital clinic. All applicable services are listed in the telemedicine audio/visual and audio-only fee schedules.

2.3 PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH THERAPY SERVICES

MDHHS will allow select therapy services to be provided via telemedicine when performed by Medicaid-enrolled private practice and outpatient hospital physical therapy (PT), occupational therapy (OT) and speech therapy (ST) providers. PT, OT and ST services allowed via telemedicine will be represented by applicable CPT/HCPCS codes on the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate for the individual beneficiary.

Documentation re-evaluation, performance, and treatment elements that typically require hands-on contact for measurement or assessment must include a thorough description of how the assessment or performance findings were established via telemedicine. This includes, but is not limited to, such elements as standardized tests, strength, range of motion, and muscle tone.

Initial PT and OT evaluations and oral motor/swallowing services are not allowed via telemedicine and should be provided in-person.

Services that require utilization of equipment during treatment and/or physical hands-on interaction with the beneficiary cannot be provided via telemedicine.

Therapy re-evaluations performed via telemedicine must be provided by a therapist whose facility/clinic has previously evaluated and/or treated the beneficiary in-person.

Durable Medical Equipment (DME) re-assessments performed via telemedicine must be provided by a therapist who has previously evaluated and/or treated the beneficiary in-person, otherwise an in-person visit is required.

This policy supplements existing PT, OT, and ST services policy. All current therapy referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether

the service is provided through telemedicine. All telemedicine therapy services will count toward the beneficiary's therapy service limits. (Refer to the Therapy Services chapter for additional information.)

2.3.A. Billing Considerations

Modifier 95 should be used in addition to the required modifiers for therapy services as outlined in therapy policy.

2.3.B. School Services Program Considerations

School Services Program (SSP) PT and OT services, as outlined in this policy, will also be allowed via telemedicine. These services must meet all other telemedicine policies as outlined.

2.4 Audiology Services

MDHHS will allow speech therapy, auditory rehabilitation, select hearing device adjustments, programming, device performance evaluations, and education or counseling to be performed via telemedicine (simultaneous audio/visual). Remote device programming must be provided in compliance with current U.S. Food and Drug Administration (FDA) guidelines. Auditory brainstem response (ABR) and auditory evoked potential (AEP) testing may also be conducted via telemedicine when performed using remote technology located at a coordinating clinical site with appropriately trained staff (i.e., mobile unit, office/clinic, or hospital).

Reimbursable procedure codes are limited to the specific set of audiology codes listed in the telemedicine fee schedule. Audiology services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate.

Audiological diagnostic tests (other than those mentioned above), hearing aid examinations, surgical device candidacy evaluations, and other audiology and hearing aid services conducted via telemedicine are not reimbursable by Michigan Medicaid and should be provided in-person.

This policy supplements the existing audiology, hearing aid dealer and speech therapy services policies. All current referral, PA, documentation requirements, standards of care, and limitations remain in effect regardless of whether the service is provided through telemedicine. Providers should refer to the Hearing Services chapter of this Manual for complete information.

2.5 Dentistry

MDHHS will allow dentists to provide the limited oral evaluation (Current Dental Terminology [CDT] code D0140) via telemedicine (simultaneous audio/visual) technology so long as all other telemedicine policy is followed.

All requirements of the general telemedicine policy must be followed when providing the limited oral evaluation via telemedicine, including scope of practice requirements, contingency plan, and the use of both audio/visual service delivery unless otherwise indicated by federal guidance.

Services delivered to the beneficiary via telemedicine must be done for the convenience of the beneficiary, not the convenience of the provider. Services must be performed using simultaneous

audio/visual capabilities. All services using telemedicine must be documented in the beneficiary's record, including the date, time, and duration of the encounter, and any pertinent clinical documentation required per CDT code description. The provider is responsible for ensuring the safety and quality of services provided with telemedicine technologies.

Billing instructions depend upon the claim format used:

- American Dental Association (ADA) Claim Format: Use POS 02 or POS 10.
- Institutional Claim Format: POS 02 and POS 10 are not required; Use modifier 95.

2.6 Vision

Telemedicine vision services can be provided through a Medicaid-enrolled provider who can report E/M services as listed in the telemedicine fee schedules.

An intermediate ophthalmological exam can be provided via telemedicine for an established patient with a known diagnosis. The provider must have a previous in-person encounter with the beneficiary to ensure the provider is knowledgeable of the beneficiary's current medical history and condition. For cases in which the provider must refer the beneficiary to another provider, a consulting provider is not required to have a pre-existing provider-patient relationship if the referring provider shares medical history, past eye examinations, and any related beneficiary diagnosis with the consulting provider. Intermediate ophthalmological exam codes should not be used to diagnose eye health conditions (an initial diagnosis). When medically necessary, providers must refer beneficiaries for an in-person encounter to receive a diagnosis and/or care. Telemedicine cannot act as a replacement for recommended in-person interactions.

2.7 School Services Program (SSP)

Because of the unique circumstances regarding the delivery of services within the School Services Program (SSP), telemedicine may be the primary delivery modality for some beneficiaries; however, the decision to use telemedicine should be based on the needs or convenience of the beneficiary, and not those of the provider.

In cases where the beneficiary is unable to use telemedicine equipment without assistance, an attendant must be provided by the provider. The attendant must be trained in the use of the telemedicine equipment to the point where they can provide adequate assistance. The attendant must also be available for the entire telemedicine session; however, they should also ensure the beneficiary's privacy to the greatest extent possible. When the originating site for the service is the student's home, any cost for an attendant is not reimbursable.

Billing and reimbursement for telemedicine services are accomplished using the same methodology as other services; however, the service must be billed using POS 03—school and modifier 95 or modifier 93. Telemedicine claims for SSP are paid according to the Centers for Medicare & Medicaid Services (CMS) approved cost-based methodology used for other services provided within the program and not the information provided previously in this policy. SSP providers are not eligible for the facility fee as the facility is an integral part of the service provided and is covered under the service claim. A database of allowable telemedicine services for SSP can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.8 Durable Medical Equipment (DME) Providers

All DME providers must reference the Medical Supplier chapter of this Manual for specific requirements in the provision of services via telemedicine.

2.9 FQHCs and RHCs

2.9.A. General Information

All current Medicaid policy for telemedicine services, including definitions, requirements and parameters of telemedicine, apply to FQHCs and RHCs. FQHCs and RHCs are responsible for ensuring compliance with all telemedicine policy.

2.9.B. Distant Site Providers

Distant site services provided by qualified Medicaid enrolled providers may be covered when the qualified provider is employed by the clinic or working under the terms of a contractual agreement with the clinic. FQHCs and RHCs must maintain all practitioner contracts and provide them to MDHHS upon request.

2.9.C. Billing, Reimbursement, and Prospective Payment System (PPS)

Claims for telemedicine services must be submitted using the ASC X 12N 837 5010 form using the appropriate telemedicine HCPCS or CPT code. All telemedicine claims must include the corresponding modifier 95- "Synchronous Telemedicine Service rendered via a real-time interactive audio and video telecommunications system" or 93 - "Synchronous Telemedicine Service rendered via telephone or other real-time interactive audio-only telecommunications system" and the appropriate revenue code.

During the Medicaid provider enrollment process, contracted providers must associate to the FQHC or RHC billing NPI. Refer to the Billing & Reimbursement for Institutional Providers chapter of this Manual for further information.

The telehealth facility fee does not qualify as a face-to-face visit and does not generate the PPS payment. Telemedicine service(s) provided at the distant site that qualify as a face-to-face visit may generate the PPS payment. All current PPS rules and encounter criteria apply to telemedicine visits. Refer to the Federally Qualified Health Centers and the Rural Health Clinics chapters of this Manual and the FQHC and RHC reimbursement lists on the MDHHS website for further information. (Refer to the Directory Appendix for website information.)

PPS is reimbursed according to the billing rules described below.

FQHC/RHD Telemedicine Services Billing			
Originating Site	**Distant Site**	**Billing Rules**	**PPS for Qualifying Visit**
FQHC #1/RHC #1	FQHC #2/RHC #2	FQHC #1/RHC #1 bills the telehealth facility fee (for tracking purposes only) and FQHC #2/RHC #2 bills for professional services provided at their site.	FQHC #2/RHC #2
FQHC/RHC	Provider is employed by/contracted with the originating site FQHC/RHC	Originating site bills for the distant site provider's services per the contract.	Originating site FQHC/RHC
FQHC/RHC	Provider is not located at an FQHC/RHC site and is not employed by/contracted with the originating site FQHC/RHC	Each provider bills for services provided at their site.	No PPS
Site is not an FQHC/RHC	FQHC/RHC	Each provider bills for services provided at their site.	FQHC/RHC

If both the originating and distant sites submit identical procedure code(s) for a telemedicine visit for the same beneficiary on the same date of service, it is considered duplicate billing. MDHHS will recover payment from the appropriate FQHC, RHC, or contracted provider. Recovery will be based on the terms specified in the contract.

2.9.D. Audio-Only Services

MDHHS will allow FQHCs and RHCs to be reimbursed for identified audio-only services (those represented on the audio-only database and that are identified as qualifying visits) to generate the PPS. Clinics will be permitted to submit for reimbursement allowable audio-only service codes, as indicated above, if appropriate for the interaction with the beneficiary. Medicaid clinic billing and reimbursement requirements apply. The provider must be employed by or contracted with the FQHC or RHC, and the procedure code billed must appear on the clinic reimbursement list as a qualifying visit. The clinic reimbursement list is located on the MDHHS website.

THERAPY SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Private Practice, Outpatient, Nursing Facility, and Home Health Agency therapy providers.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services related to a CSHCS qualifying diagnosis as recommended by a CSHCS authorized subspecialist. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to CSHCS only beneficiaries.

1.1 SERVICE PROVISION

Therapy may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed or appropriately supervised professionals in the following settings:

- Occupational Therapy (OT) and Physical Therapy (PT)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)-Accredited Outpatient Medical Rehabilitation Program
  - Physical Therapist or Occupational Therapist in Private Practice
  - Physician's Office/Clinic
  - Optometrist's Office
  - Nursing Facility
  - Home Health Agency
- Speech-Language Therapy (ST)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Outpatient Medical Rehabilitation Program
  - Council on Academic Accreditation (CAA)-Accredited University Graduate Education Program
  - Speech-Language Pathologist in Private Practice

- Physician's Office/Clinic
- Nursing Facility
- Home Health Agency

Medicaid covers medically necessary rehabilitative therapy services for beneficiaries of all ages. Rehabilitative services include teaching or training someone to perform or develop a level of reasonable functional proficiency of tasks or skills that were previously learned, with or without compensatory strategies. Examples may include, but are not limited to:

- PT to regain functional ambulation using a cane following a stroke, or to advance from ambulation with an assistive device/physical assistance to ambulation without an assistive device or physical assistance;
- OT to achieve independent dressing following a spinal cord injury, or to develop dressing independence without an assistive device or physical assistance;
- Speech-Language Pathology (SLP) to improve articulation and fluency following an acquired or traumatic brain injury or develop communication skills utilizing an augmentative communication strategy.

Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. Habilitation therapy includes teaching/training someone to perform/develop a level of reasonable functional proficiency of a task that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes. Examples may include, but are not limited to:

- PT for a child who is not walking at a typically expected age.
- OT teaching normal dressing skills beyond the typically expected age of learning.
- SLP for communication skills including articulation errors beyond the typically expected age of learning or syntax and semantics for a person with significant hearing impairment.

Documentation must objectively support the request for rehabilitative and/or habilitative therapy.

1.2 Therapy Database

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the MDHHS Therapies Database on the MDHHS website or the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS). (Refer to the Directory Appendix for website information.) The database includes covered private practice, outpatient, nursing facility, and home health therapy codes, applicable limits, and prior authorization requirements.

1.3 Documentation in Beneficiary Medical Record

Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed. Documentation must also include the treatment time of the services performed.

1.4 Practitioner Signatures

In all documentation requiring a signature, the signature must be hand written by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. NOTE: An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.5 Modifiers

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the plan of care under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, when services are habilitative report with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related. Therapy services submitted without these modifiers may be denied.

Outpatient hospital facility providers must also report the appropriate therapy assistant modifier when services are furnished in whole or in part by a physical therapy or occupational therapy assistant. In cases where both a physical or occupational therapist and a physical or occupational therapist assistant (PTA/OTA) provide a portion of the same untimed service or 15-minute timed unit of service, Medicaid will utilize Medicare's de minimis standard in determining if the service/unit is considered to be furnished in whole or in part by a PTA or OTA.

Refer to the Billing and Reimbursement chapters in this manual for additional modifier information.

1.6 Reimbursement

Reimbursement structure is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System or the Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in CHAMPS or the MDHHS Therapies Database on the MDHHS website.) For Not Otherwise Classified codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved prior authorization request.

Students, graduates, educational limited temporary licensed therapists, and assistants are not eligible to enroll or be directly reimbursed by Medicaid. Services performed by these individuals are required to be reported under the National Provider Identifier (NPI) of the supervising therapist.

1.7 Other Insurance [Subsection Added 4/1/25]

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. Providers should refer to the Coordination of Benefits chapter for more information. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. **(text added 4/1/25)**

SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and rehab agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. All CORFs and rehab agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES-ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must not be part of, or owned by, a hospital, CORF or rehab agency. All CARF-accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 NURSING FACILITY

A Medicaid-certified nursing facility (NF) is defined as a nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech-language pathologist who meets applicable licensure/certification/accreditation requirements. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

2.5 HOME HEALTH AGENCY

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, OT, PT, ST and home health aide services. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation.

OT, PT, and ST services may be provided by an HHA if Medicare/Medicaid Conditions of Participation, including medical necessity, are met. A therapist in the home health setting may be responsible for supervision of the home health aide. Refer to the Home Health chapter for additional information.

2.6 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient speech-language therapy provided

by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or rehab agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.7 Physical Therapists, Occupational Therapists, and Speech-Language Pathologists' Private Practice [Change Made 4/1/25]

PT, OT, and ST services may be provided to beneficiaries of all ages when provided by a Medicaid enrolled physical therapist, occupational therapist, or speech-language pathologist employed by an individual/sole proprietor, **(text added 4/1/25)** partnership, or group practice. These providers are eligible for direct reimbursement.

2.8 Physician's Office or Clinic

PT, OT, and ST services may be provided to beneficiaries of all ages in a physician's office or one of the following clinics: Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.

SECTION 3 – PRIOR AUTHORIZATION REQUESTS [CHANGE MADE 4/1/25]

Prior authorization is required for certain therapy services before the services are rendered, dependent upon the Standards of Coverage for each provider type. To determine which therapy services require prior authorization, and when, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, and/or **(revised 4/1/25)** the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Home Health Therapy	Prior authorization (PA) is not required for the initiation of home health physical and occupational therapy services for up to a maximum of 24 visits within one 60 consecutive-day period per calendar year. The first date of therapy service during the calendar year starts the 60-day period. PA is required if therapy is needed beyond the 24 visits within the 60-day period, or if the beneficiary has previously received home health therapy within the calendar year. PA is needed when therapy limits are exceeded regardless of diagnosis. Continued therapy may be authorized for periods not to exceed 60-days. Home Health speech therapy is only covered for CSHCS beneficiaries and requires PA for visits beyond initial evaluation.
Nursing Facility Therapy	Providers must obtain PA for therapy services that are provided after the initial 60-day post-admission period. This includes new episodes of therapy or continuations of therapy already in progress and is not dependent on the amount of therapy performed during the admission period. Continued therapy may be authorized for periods not to exceed 60-days. Subsequent emergency or planned hospitalizations do not impact the requirements for PA. A copy of the physician prescription or documented medical clearance to resume therapy must be retained in the beneficiary's medical record. Nursing facilities participating in Medicare are not required to obtain PA for the deductible and/or coinsurance amounts when Medicare approves the services. If a beneficiary is approved for ventilator care and requires therapy, PA for the therapy must be obtained under the Ventilator Dependent Care Unit (VDCU) National Provider Identification (NPI).
Outpatient/ Private Practice Therapy	PA is needed when therapy limits are exceeded regardless of diagnosis. Continued therapy may be authorized for periods not to exceed six months.

3.1 FORM AND COMPLETION INSTRUCTIONS [CHANGES MADE 4/1/25]

Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.

The information on the MSA-115 must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the required signatures and appropriate procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and mihealth card ID number, provider name and facility address, and the provider's billing NPI number. **(revised 4/1/2025)**

Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.

Prior authorization requests must be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. When the therapy is habilitative, a modifier that represents the nature of the therapy being requested must also be reported. Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.

For all Medicaid Fee-for-Service (FFS) beneficiaries, prior authorization requests should be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic PA request. Prior authorization requests (MSA-115) may also be faxed or mailed to the MDHHS Program Review Division.

Providers can check the status of a PA request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.) **(text revised 4/1/2025)**

A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.

3.2 Emergency/Verbal Prior Authorization [Changes Made 4/1/25]

A provider may contact MDHHS to obtain a verbal prior authorization when the prescribing practitioner (practicing within their scope of practice as defined by state law) has indicated that it is medically necessary to provide therapy services without delay. If the initiation of a therapy service is required during MDHHS nonworking hours, providers may perform the service and call the Program Review Division by the end of the next working day.

To obtain verbal prior authorization, providers may call the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.) **(revised 4/1/2025)**

The following steps must be completed before a prior authorization number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.
- The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted with the prior authorization request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible for Medicaid when the therapy service was provided.
- The Program Review Division does not receive the completed MSA-115 and documentation within 30 days of the verbal authorization.

- The prescription is dated after the date the verbal authorization was requested.

3.3 Retroactive Prior Authorization

Therapy services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive prior authorization will be denied.

3.4 Beneficiary Eligibility

Approval of a therapy service on the prior authorization request confirms that the service is authorized for the beneficiary. Approval of a prior authorization request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility prior to rendering the service.

3.5 Billing Authorized Services

After prior authorization is issued, the information (e.g., prior authorization number, HCPCS/ CPT procedure code, modifier, and quantity) that was approved on the prior authorization must match the information on the claim form.

Therapy rendered to a nursing facility beneficiary must be billed by the nursing facility.

Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.

SECTION 4 – SPECIAL COVERAGE CONSIDERATIONS [SECTION ADDED 4/1/25]

Services under this section must also meet the requirements outlined within the occupational, physical, and speech-language therapy sections of this chapter. **(text added 4/1/2025)**

4.1 DUPLICATION OF SERVICES [SUBSECTION ADDED 4/1/25]

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, sitting and standing balance/tolerance, hand therapy, transfers, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes. **(text relocated/revised 4/1/2025)**

4.2 TELEMEDICINE [SUBSECTION ADDED 4/1/25]

Medicaid allows select therapy services to be provided via telemedicine when performed by private practice and outpatient hospital therapy providers. Services allowed via telemedicine will be represented by applicable CPT/HCPCS codes from the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate for the individual beneficiary. Refer to the Telemedicine Chapter, Physical Therapy, Occupational Therapy, and Speech Therapy Services subsection, for additional information regarding telemedicine services. **(text added 4/1/2025)**

4.3 SERIAL CASTING [SUBSECTION ADDED 4/1/25]

Serial casting is a process in which a joint(s) that lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion. Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence, via signature, of any treatment plan that includes serial casting. **(text relocated/revised 4/1/2025)**

4.4 SUPPLIES, EQUIPMENT, AND ROOM COSTS [SUBSECTION ADDED 4/1/25]

Therapy services are considered all-inclusive charges. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated.

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy. **(text relocated/revised 4/1/2025)**

4.5 Therapy for Beneficiaries with Autism Spectrum Disorder [Re-numbered 4/1/25]

Beneficiaries diagnosed with autism spectrum disorder (ASD) who have been determined eligible by the Prepaid Inpatient Health Plan (PIHP) for specialty Behavioral Health Treatment (BHT) services may also have any related OT, PT, and ST services covered through the PIHP when the therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy services covered by the PIHP must meet the criteria outlined within the Program Requirements section (Medical Necessity Criteria subsection) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. Providers should also refer to the Covered Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information.

Medicaid does not require beneficiaries to be referred to or access therapy services through the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program prior to, or in lieu of, accessing therapy through the PIHP when the therapy is related to the beneficiary's ASD diagnosis.

4.6 Access to Services for School-Aged Beneficiaries [Subsection Added 4/1/25]

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically based therapy services in an outpatient setting, nursing facility, or through a home health agency. Medically based therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Medicaid does not require a school-aged beneficiary to be referred to or access therapy services through the School Services Program (SSP) benefit prior to, or in lieu of, accessing medically based therapy in the community. Participation in therapy in one setting is not intended to replace services in the other setting.

If therapy is provided in more than one setting, the goals and purpose for each must be distinct. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to the Requirements of Continued Therapy for additional information.) **(text relocated/revised 4/1/2025)**

4.7 Aquatic Therapy [Subsection Added 4/1/25]

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code

describing the covered procedure if the service meets all Medicaid coverage requirements. **(text relocated/revised 4/1/2025)**

4.8 Group Therapy [Subsection Added 4/1/25]

PT and/or OT are not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one- to-one) contact between the beneficiary and the therapist.

Speech group therapy requires documentation justifying the benefit of group therapy in addition to, or in place of, individual therapy. No more than one session of individual speech-language therapy and one session of group speech-language therapy may be provided on the same date of service. Group therapy is not covered in the home setting. **(text relocated/revised 4/1/2025)**

4.9 Co-Treatment Therapy [Subsection Added 4/1/25]

Co-treatment is a single treatment session in which two therapists from different disciplines work together as a team to address a beneficiary's condition and meet their treatment goals. Medicaid covers outpatient and nursing facility co-treatment therapy when medically necessary for the beneficiary to receive multi-disciplinary therapy during the same treatment session. The two therapists must not work on duplicate treatment goals. Standards of coverage and service limitations for each discipline participating in the co-treatment are identical to those applicable to therapy provided on an individual basis.

The decision to co-treat should be made on a case-by-case basis and be provided solely for the medical benefit of the beneficiary. Co-treatment therapy is not covered when provided for convenience purposes or when the assistance of an additional therapist is requested solely for safety reasons. **(text relocated/revised 4/1/2025)**

4.9.A. Prior Authorization [Subsection Added 4/1/25]

Co-treatment therapy must be prior authorized (PA). Each therapist requesting co-treatment must submit a separate PA to MDHHS; however, both requests should be submitted at the same time. If a PA request includes both individual and co-treatment therapy, the therapist must designate which procedure code, units, frequency, or service dates will be utilized in the co-treatment intervention. Documentation of the beneficiary's evaluation/re-evaluation, individualized treatment plan and short- and long-term goals, and progress should be discipline-specific and submitted with each of the therapist's PA requests.

In addition, the documentation must:

- Support the discipline-specific clinical need and appropriateness of the co-treatment services;
- Demonstrate how the co-treatment will help achieve the therapist's goals more effectively than separate, individual treatment sessions;
- Identify the co-treating discipline; and

- Indicate the anticipated length of time (in sessions or weeks/months) that the beneficiary will require co-treatment rather than individual sessions. **(text relocated/revised 4/1/2025)**

4.9.B. BILLING REQUIREMENTS [SUBSECTION ADDED 4/1/25]

Refer to the Billing & Reimbursement chapters of this manual for specific billing guidelines related to co-treatment therapy. **(text relocated/revised 4/1/2025)**

(Section 4 – Standards of Coverage and Service Limitations was re-formatted. Text was re-formatted into three (3) individual sections:

- **Section 5 – Occupational Therapy**
- **Section 6 – Physical Therapy**
- **Section 7 – Speech Language Therapy)**

SECTION 5 – OCCUPATIONAL THERAPY [SECTION RE-FORMATTED/ADDED 4/1/25]

5.1 STANDARDS OF COVERAGE AND SERVICE LIMITATIONS [RE-NUMBERED, RE-TITLED AND CHANGES MADE 4/1/25]

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for occupational therapy services when provided by any of the following:

- A licensed occupational therapist.
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising occupational therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) an occupational therapist. All documentation must be reviewed and co-signed by the supervising occupational therapist.

MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association.

Rehabilitative OT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Habilitative OT must be medically necessary, reasonable and required to develop a reasonable functional status that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid's standard of coverage for **rehabilitative and habilitative** therapy allows the following:

Outpatient/Private Practice Occupational Therapy	Nursing Facility Occupational Therapy	Home Health Occupational Therapy
• Up to 144 units of OT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• OT performed within 60 days of the beneficiary's admission to the facility. • Prior authorization is required for continued treatment beyond the initial 60-day post admission period.	• Up to 24 visits of OT in one 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

OT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Healthy Michigan Plan.

Medicaid covers maintenance therapy when the skills of a therapist are required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices.

Medicaid's standard of coverage for **maintenance therapy** allows the following:

Outpatient/Private Practice Maintenance Occupational Therapy	Nursing Facility Maintenance Occupational Therapy	Home Health Maintenance Occupational Therapy
• Up to four sessions/visits per 90-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Up to four sessions/visits per 60-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Up to four sessions/visits per 60-consecutive day period. • Prior authorization is required for treatment that exceeds visit limitation.

Medicaid only covers OT services that require the skills, knowledge, and education of an occupational therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, physical therapist, family member, teacher, etc.).

Occupational therapy may be covered for one or more of the following:	▪ Therapeutic use of everyday life activities/occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration). ▪ Design, fabrication, application, or training in the use of assistive technology or orthotic/prosthetic devices. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by the beneficiary, family or caregivers. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.) *Covered occupations include: ▪ Activities of daily living (self-care activities). ▪ Instrumental activities of daily living (multistep activities to care for self and others, such as household management and childcare).
Occupational therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.).

	▪ Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO. ▪ Feeding for a beneficiary who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO). ➢ Services covered by the facility's per diem rate, including diversional OT, reality orientation, restorative nursing functions, routine maintenance, or the development of the therapy and treatment plan. **(text relocated/revised 4/1/2025)**

5.2 Prescription Requirements [Re-numbered & Changes Made 4/1/25]

Outpatient hospital, private practice, and nursing facility therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for occupational therapy. Home Health requires a prescription from a physician, physician assistant, nurse practitioner, or clinical nurse specialist for occupational therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy). All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription. **(text relocated/revised 4/1/2025)**

5.3 Service Requirements [New Subsection/Re-formatted & Changes Made 4/1/25]

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Evaluations of swallowing function may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. OT evaluations/re-evaluations must be completed and signed by the occupational therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short- and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; and ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.

Treatment Plan/Plan of Care	The OT treatment plan that results from the evaluation/re-evaluation must be medically necessary, signed and dated by the occupational therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with each prior authorization request.
Initiation of Services	OT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for occupational therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., a speech-language pathologist may not provide treatment under an occupational therapist's evaluation); and ▪ There is a change in medical status resulting in decreased activities of daily living skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The occupational therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months). ▪ If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.
Maintenance Visits	The skills of an occupational therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. The occupational therapist must request prior authorization to continue maintenance therapy beyond the standard coverage limitations, even if the beneficiary changes providers. The occupational therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating occupational therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable.

	▪ The anticipated frequency and duration of maintenance visits. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care above.
Discharge Summary	MDHHS requires the occupational therapist to document a discharge summary to identify the completion of OT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following: ▪ Dates of service (i.e., initial and discharge dates); ▪ Description of therapy services provided; ▪ Functional status at discharge related to treatment areas/goals/maximum functional achievement over the course of therapy; ▪ Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status; ▪ A copy or description of the maintenance program, if appropriate; ▪ Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and ▪ Recommendations/referral to other services, if appropriate. **(text relocated/revised 4/1/2025)**

SECTION 6 – PHYSICAL THERAPY [SUBSECTION ADDED FOR RE-FORMATTED TEXT 4/1/25]

6.1 STANDARDS OF COVERAGE AND SERVICE LIMITATIONS [RE-NUMBERED, RE-TITLED AND CHANGES MADE 4/1/25]

MDHHS uses the terms Physical Therapy, PT, and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for physical therapy services when provided by any of the following:

- A licensed physical therapist.
- A licensed physical therapy assistant under the supervision of a physical therapist (i.e., the physical therapy assistant services must follow the evaluation and treatment plan developed by the physical therapist, and the physical therapist must supervise and monitor the physical therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising physical therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a physical therapist. All documentation must be reviewed and co-signed by the supervising physical therapist.

MDHHS expects physical therapists and physical therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association.

Rehabilitative PT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Habilitative PT must be medically necessary, reasonable and required to develop a reasonable functional status that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid's standard of coverage for **rehabilitative and habilitative** therapy allows the following:

Outpatient/Private Practice Physical Therapy	Nursing Facility Physical Therapy	Home Health Physical Therapy
• Up to 144 units of PT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• PT performed within 60 days of the beneficiary's admission to the facility. • Prior authorization is required for continued treatment beyond the initial 60-day post admission period.	• Up to 24 visits of PT in one 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

PT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform mobility skills appropriate to their chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid covers maintenance therapy when the skills of a therapist are required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices.

Medicaid's standard of coverage for **maintenance therapy** allows the following:

Outpatient/Private Practice Maintenance Physical Therapy	Nursing Facility Maintenance Physical Therapy	Home Health Maintenance Physical Therapy
• Up to four sessions/visits per 90-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Up to four sessions/visits per 60-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Up to four sessions/visits per 60-consecutive day period. • Prior authorization is required for treatment that exceeds visit limitation.

Medicaid only covers PT services that require the skills, knowledge, and education of a physical therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed occupational therapist, family member, teacher, etc.).

Physical therapy may be covered for one or more of the following:	▪ If expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills. ▪ PT service that is diagnostic. ▪ For a temporary condition that creates decreased mobility and/or function. ▪ Training in functional mobility skills (e.g., ambulation, transfers, floor mobility, transitions, wheelchair mobility, etc.). ▪ Stretching for improved flexibility. ▪ Modalities to allow gains of function, strength, or mobility. ▪ Training in the use of orthotic/prosthetic devices and assistive technology devices. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by the beneficiary, family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)
Physical therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO); ➢ Services covered by the facility's per diem rate, including routine maintenance and the development of the therapy and treatment. **(text relocated/revised 4/1/2025)**

6.2. Prescription Requirements [Re-numbered & Change Made 4/1/25]

Outpatient hospital, private practice, and nursing facility therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for physical therapy. Home Health requires a prescription from a physician, physician assistant, nurse practitioner, or clinical nurse specialist for physical therapy.

A treatment plan meeting all of the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services; and
- Diagnosis.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription. **(text relocated/revised 4/1/2025)**

6.3 Service Requirements [New Subsection/Re-formatted & Changes Made 4/1/25]

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. PT evaluations/re-evaluations must be completed and signed by the physical therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;

	▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan/Plan of Care	The PT treatment plan that results from the evaluation must be medically necessary, signed and dated by the physical therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency, and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with each prior authorization request.
Initiation of Services	PT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for physical therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., occupational therapist cannot provide treatment under a physical therapist's evaluation); and ▪ There is a change in medical status resulting in decreased mobility skills or functional ability.

Requirements of Continued Therapy	The physical therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established in this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). ▪ If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.
Maintenance Visits	The skills of a physical therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. The physical therapist must request prior authorization to continue maintenance therapy beyond the standard coverage limitations, even if the beneficiary changes providers. The physical therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating physical therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested; ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period; ▪ A copy or description of the maintenance program; ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ The anticipated frequency and duration of the maintenance visits;

	▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months); A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).
Discharge Summary	MDHHS requires the physical therapist to document a discharge summary to identify the completion of PT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following: ▪ Dates of service (i.e., initial and discharge dates); ▪ Description of therapy services provided; ▪ Functional status at discharge related to treatment areas/goals/maximum functional potential over the course of therapy; ▪ Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status; ▪ A copy or description of the maintenance program, if appropriate; ▪ Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and ▪ Recommendations/referral to other services, if appropriate. **(text relocated/revised 4/1/2025)**

SECTION 7 – SPEECH-LANGUAGE THERAPY [SUBSECTION ADDED FOR RE-FORMATTED TEXT 4/1/25]

7.1 STANDARDS OF COVERAGE AND SERVICE LIMITATIONS [RE-NUMBERED, RE-TITLED AND CHANGES MADE 4/1/25]

MDHHS uses the terms speech therapy, SLP, speech-language pathology, speech-language therapy (ST), and therapy to mean speech and language services and speech-language therapy. Speech-language therapy is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses services for speech-language therapy when provided by any of the following:

- A speech-language pathologist with a current license. Out-of-state therapists must be licensed and/or be certified by the appropriate standard-setting authority in the state in which they are practicing. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter for more information.)
- An appropriately supervised speech-language pathologist Educational Limited Temporary licensee completing their postgraduate clinical experience or having completed all requirements but has not yet obtained a full license. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed speech-language pathologist. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.

MDHHS expects speech-language pathologists to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association.

Rehabilitative ST must be medically necessary, related to a medical diagnosis, reasonable, and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; and
- Prevent a reduction in medical or functional status had the therapy not been provided.

Speech-Language therapy is limited to services for:

- Articulation
- Language
- Fluency
- Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration)
- Training in the use of a speech-generating device (SGD)/Augmentative and Alternative Communication (AAC) device/Augmentative Communication Device (ACD)
- Evaluation and instruction in the use of an oral-pharyngeal prosthesis

- Voice
- Rehabilitation of executive skills function status post neurological insult (examples may include reasoning, decision making, judgement, and language)
- Audiologic/Aural Rehabilitation

Habilitative Speech-Language therapy must be medically necessary, reasonable and required to develop a reasonable functional status that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes.

ST provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid's standard of coverage for **rehabilitative and habilitative** therapy allows the following:

Outpatient/Private Practice Speech-Language Therapy	Nursing Facility Speech-Language Therapy	Home Health Speech-Language Therapy
• Up to 36 visits of ST per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• ST performed within 60 days of the beneficiary's admission to the facility. • Prior authorization is required for continued treatment beyond the initial 60-day post admission period.	• Home Health ST is covered for CSHCS beneficiaries only. • Prior authorization is required.

ST is expected to result in a measurable improvement that is significant to the beneficiary's ability to demonstrate communication and/or oral motor function appropriate to their chronological, developmental, cognitive, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid covers maintenance therapy when the skills of a speech-language pathologist are required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices.

Medicaid's standard of coverage for **maintenance therapy** allows the following:

Outpatient/Private Practice Maintenance Speech-Language Therapy	Nursing Facility Maintenance Speech-Language Therapy	Home Health Maintenance Speech-Language Therapy
• Up to four sessions/ visits per 90-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Up to four sessions/ visits per 60-consecutive day period. The four sessions should not total more than 16 units. • Prior authorization is required for treatment that exceeds visit or unit limitations.	• Home Health ST is covered for CSHCS beneficiaries only. • Up to four sessions/ visits per 60-consecutive day period. • Prior authorization is required.

Medicaid only covers ST services that require the skills, knowledge, and education of a speech-language pathologist. MDHHS does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed physical therapist, family member, teacher, etc.).

Speech-Language therapy that is related to a medical diagnosis may be covered for one or more of the following:	▪ It is expected to result in the restoration or amelioration of the beneficiary's ability to communicate wants, needs, and desires to their previous level of function following illness or injury. ▪ A temporary condition that results in decreased comprehension and expression, fluency, and/or oral function. ▪ Training to improve articulation. ▪ Training to improve receptive and expressive language. ▪ Training to improve fluency. ▪ Training to improve oral and/or pharyngeal phases of swallowing. ▪ Training in the use of a SGD/AAC/ACD device. ▪ Training in the use of an oral-pharyngeal prosthesis. ▪ Training in voice disorders. ▪ Training in the use of compensatory communication strategies. ▪ Training in restoration of executive skill functions. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by the beneficiary, family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)

Speech-Language therapy is not covered for the following:	▪ If provided solely for educational, vocational, social/emotional, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO. ▪ Feeding for a beneficiary who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO) is not a covered benefit for beneficiaries in a nursing facility. ➢ Services covered by the facility's per diem rate, including routine maintenance and the development of the therapy and treatment. **(text relocated/revised 4/1/2025)**

7.2 Prescription Requirements [Re-numbered & Changes Made 4/1/25]

Outpatient hospital, private practice, and nursing facility therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for speech-language therapy. Home health therapy requires a prescription from a physician for speech-language therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;

- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy. All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription. **(text relocated/revised 4/1/2025)**

7.3 Service Requirements [New Subsection/Re-formatted & Changes Made 4/1/25]

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Oral function or swallowing evaluations may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. Speech-Language therapy evaluations/re-evaluations must be completed and signed by the speech-language pathologist and include all the following: ▪ Standardized tests and/or objective functional baseline measures used to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ Assessment of the beneficiary's performance components (e.g., functional communication, receptive, expressive, articulation, fluency, voice, oral function, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).

	Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.
Treatment Plan/Plan of Care	The ST treatment plan that results from the evaluation must be medically necessary, signed and dated by the speech-language pathologist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication and/or oral motor function needs; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with each prior authorization request.
Initiation of Services	Speech-Language therapy may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for speech-language therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., an occupational therapist cannot provide treatment under a speech-language pathologist's evaluation); and ▪ If there is a change in medical status resulting in decreased communication skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The speech-language pathologist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be submitted with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). ▪ If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.
Maintenance Visits	The skills of a speech-language pathologist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by the beneficiary, family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. The speech-language pathologist must request prior authorization to continue maintenance therapy beyond the standard coverage limitations, even if the beneficiary changes providers. The speech-language pathologist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. The summary must include the treating speech-language pathologist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-consecutive day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary.

	▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of the maintenance visits. ▪ The anticipated discharge plan for the current course of therapy (up to 12 consecutive months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).
Discharge Summary	MDHHS requires the speech-language pathologist to document a discharge summary to identify the completion of speech-language therapy services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following: ▪ Dates of service (i.e., initial and discharge dates); ▪ Description of therapy services provided; ▪ Functional status at discharge related to treatment areas/goals/maximum functional achievement over course of therapy; ▪ Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status; ▪ A copy or description of the maintenance program, if appropriate; ▪ Identification of assistive technology devices provided (e.g., SGD/AAC, switches) and its current utilization, if appropriate; and ▪ Recommendations/referrals to other services, if appropriate. **(text relocated/revised 4/1/2025)**

7.4 Evaluations and Follow-Up for Speech-Generating Devices/Voice Prostheses [Re-numbered & Changes Made 4/1/25]

Speech generating devices (SGDs) provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet their daily communication needs. To be considered for SGD coverage, a SLP must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities. The SLP SGD evaluation should be conducted in conjunction with other disciplines including an occupational therapist and/or physical therapist to address functional abilities that impact the ability to utilize an SGD. These functional abilities include, but are not limited to, motor skills, accessing, positioning needs, and vision. The results of the PT/OT evaluation must be shared with the SLP so that it can be included with the SLP's evaluation.

Prior authorization is required for all SGDs. The Special Services Prior Approval-Request/Authorization form (MSA-1653-B) must be submitted for all original, replacement, upgrade, or repair of SGDs. (Refer to the Forms Appendix for additional information.) The SLP evaluation must be shared with the provider submitting the SGD prior authorization request. Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional coverage and PA information regarding SGDs.

The speech-language pathologist evaluation for recommendation of a SGD may be billed once in three years. Prior authorization is required for evaluations exceeding standard coverage limitations.

SGD set-up, programming, and modification services that require the skills of a speech-language pathologist (beyond those provided by the SGD vendor) are covered as part of the beneficiary's ST benefit and may be billed up to 36 visits per calendar year.

An evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech may be billed only if the evaluation was done to determine the need for an electro-larynx. The evaluation may be provided once in three years. **(text relocated/revised 4/1/2025)**

TRIBAL HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).

The Michigan Department of Health and Human Services (MDHHS), which administers the State Medicaid Agency (SMA), has the authority to enter into reimbursement agreements with THCs to establish a payment mechanism for Medicaid beneficiaries receiving outpatient services through a THC.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of four reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are:

- A THC may choose to be certified as an IHS facility and receive the IHS outpatient all-inclusive rate (AIR) for eligible encounters. The AIR applies to encounters for both native and non-native Medicaid beneficiaries. THCs are reimbursed at the AIR unless the THC chooses a different payment option and informs MDHHS of this choice in writing.
- If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers Chapter.
- A Tribal facility may choose to enroll as a Tribal FQHC and be reimbursed for outpatient face-to-face visits within the FQHC scope of services provided to Medicaid beneficiaries, including telemedicine and services provided by contracted employees. Tribal FQHCs are eligible to receive the IHS outpatient AIR for eligible encounters.
- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

In addition, eligible prescriptions dispensed by THC and Tribal FQHC pharmacies constitute a separate encounter per prescription and are reimbursed the IHS outpatient AIR. The AIR applies to prescriptions for both native and non-native Medicaid beneficiaries.

Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Understanding (MOU). THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native Medicaid beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity.

SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT

MDHHS requires all THCs to have a Type 2 (Organization) National Provider Identification (NPI) number in order to receive the enhanced THC reimbursement. For THCs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the THC fails to obtain and/or use the correct NPI number, the THC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

2.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICES

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. Services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

2.2 NONENROLLED PROVIDERS

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.

SECTION 3 – BENEFITS

3.1 COVERED SERVICES [CHANGE MADE 7/1/2025]

THC services are reimbursed at the current Medicaid fee screens and reconciled annually, if applicable, for services provided to Medicaid fee-for-service (FFS) or managed care beneficiaries. THC Medicaid services include:

- Physician (MD, DO) services
- Podiatrist (DPM) services
- Chiropractor (DC) services
- Optometrist (OD) services
- Dental (DDS, DT, RDH) services
- Advanced practice registered nurse (APRN) services
- Physician assistant (PA) services
- Services and supplies incident to the services rendered by the provider:
  - Pharmacy services administered by the provider and billed under the provider's NPI number
  - Laboratory services billed under the provider's NPI number
  - Diagnostic services billed under the provider's NPI number
- Therapies (i.e., Occupational, Physical, and Speech, Hearing, and Language Evaluation and Therapy) rendered under the physician's NPI number

The services listed may be modified in accordance with benefits covered under the Medicaid State Plan. MDHHS notifies providers of changes (additions/deletions) in Medicaid covered services through the Medicaid bulletin process. Providers should refer to these documents to verify that benefits are covered prior to rendering services.

For clarification of covered services:

Physician Services	Physician services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Podiatrist Services	Podiatrist services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Chiropractor Services	Chiropractor services must comply with the coverages and limitations published in the Chiropractor Chapter of this manual and MDHHS Bulletins.

Maternal Infant Health Program (MIHP)	THCs providing Maternal Infant Health Program (MIHP) services must be certified through MDHHS. Information specific to the coverages and limitations for MIHP services are detailed in the Maternal Infant Health Program Chapter of this manual. MIHP related services rendered to fee-for-service beneficiaries must be billed on the ASC X12N 837 5010 professional format. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines. If the THC subcontracts any MIHP services, no duplicate billing is permitted.
Physician's Assistant	Physician's assistant services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Advanced Practice Registered Nurse (APRN)	APRN services must comply with the coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Pharmacy Services	Pharmacy services billed under the practitioner NPI number are included in the encounter rate but do not constitute a separate encounter as they are considered part of the office visit. Practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with enrolled pharmacy providers may continue to bill prescription claims for FFS beneficiaries to the MDHHS Pharmacy Benefits Manager (PBM). For beneficiaries enrolled in a health plan, prescription claims are billed to the health plan's PBM. **(text added 7/1/2025)** Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. MTM services provided according to Medicaid policy may be eligible to receive the encounter rate. (Refer to the Pharmacy Chapter of this manual for additional information.) MDHHS contracts with a PBM for processing of all fee-for-service (FFS) pharmacy claims for Medicaid. (Refer to the Pharmacy Chapter of this manual for an explanation of coverages and limitations.)
Laboratory Services	The Laboratory Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner's NPI number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit. THCs cannot bill for any services rendered by an outside laboratory provider or for an outside laboratory's employees performing tests.
Diagnostic Services	Diagnostic testing performed as part of an office visit must be directly related to the presenting condition and substantiated in the medical records. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for billing information.) Diagnostic testing services do not constitute a separate encounter. These services are regarded as part of the office visit and are included in the encounter reimbursement. Examples of diagnostic tests are allergy testing, audiologic function tests, x-rays, and EKGs.

Telemedicine	A THC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Chapter for additional information regarding telemedicine services. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.
Therapies	Physical therapy, speech therapy, and occupational therapy are covered when performed at the THCs. Refer to the appropriate chapter of this manual and MDHHS Bulletins for an explanation of current coverages and limitations. The Billing & Reimbursement for Professionals Chapter of this manual describes the billing requirements for services provided. Therapies provided on the same date of service as a physician visit are included in the encounter reimbursement.

3.2 Dental Coverages and Limitations

THC dental services are covered if provided in the THC and must comply with coverages and limitations for dental services as specified in the Dental Chapter of this manual. Dental benefits covered for beneficiaries under the age of 21 differ from those covered for beneficiaries age 21 and over.

Information for billing dental services is published in the Billing & Reimbursement for Dental Providers Chapter of this manual.

MDHHS contracts with Dental Health Plans (DHPs) for the administration of dental services for ***Healthy Kids Dental*** (HKD) beneficiaries. Claims for services provided to beneficiaries enrolled in the HKD program should be submitted to the beneficiary's DHP. Payment is made based on the DHP fee schedule. No additional reimbursement is made by MDHHS.

(Refer to the Directory Appendix for DHP contact information.)

3.3 Vision Coverages and Limitations

Vision services are covered if provided at the THC. Vision providers are ophthalmologists and optometrists. The vision services provided by an ophthalmologist or optometrist must comply with coverages and limitations published in the Vision Chapter of this manual.

MDHHS contracts for the volume purchase of frames and lenses from an optical house. Frames and lenses covered by the program must be ordered through the contractor and are listed in the Vision Chapter of this manual.

Some vision services require prior authorization (PA) before they can be rendered. The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. (Refer to the Vision Chapter for information on services that require PA and to the Forms Appendix for a copy of the form.)

3.4 Services Provided to Medicaid Health Plan Enrollees

For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. In the absence of an agreement or contract, payment is based on the Medicaid fee-for-service (FFS) rates in

effect on the date of service (DOS). Approved services provided to MHP enrollees are then recognized as encounters.

3.5 Medicare and Medicaid Beneficiaries

For dually eligible Medicare and Medicaid beneficiaries, Medicaid reimburses coinsurance and deductible amounts on Medicare-approved claims up to Medicare's IHS encounter rate.

SECTION 4 – SUBSTANCE ABUSE

Outpatient substance abuse services provided by physicians, clinical social workers, clinical psychologists, and substance abuse treatment specialists are reimbursed. These services may include:

- Initial complete physical
- Medical history
- Social history
- Psychiatric history
- Individual, family, and group counseling
- Outpatient substance abuse treatment
- Intensive outpatient counseling
- Therapies (i.e., Psychiatric occupational/recreational therapy) in a Tribal-operated substance abuse treatment center are covered services provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.
- Methadone

4.1 REQUIREMENTS FOR PARTICIPATION

All programs must meet the following criteria to bill Medicaid for services:

- Accredited as an alcohol and/or drug abuse program by one of the six national accreditation bodies:
  - The Joint Commission
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - American Osteopathic Association (AOA)
  - Council on Accreditation of Services for Families and Children (CASFC)
  - National Committee on Quality Assurance (NCQA)
  - Accreditation Association for Ambulatory Health Care (AAAHC)

4.2 AUTHORIZATION

Services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of the regional Prepaid Inpatient Health Plan (PIHP).

4.3 AMERICAN INDIAN AND ALASKA NATIVE SERVICES

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain substance abuse services directly from the THC. These services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs should contact their regional PIHP to determine the appropriate process for accessing other funding sources or other service providers for those individuals requiring substance abuse services not covered by the THC.

4.4 Services Provided to Non-American Indians and Alaska Natives

The MDHHS Prepaid Inpatient Health Plan (PIHP) for Specialty Developmental Disabilities, Mental Health and Substance Abuse services assumes responsibility for certifying admission/continuing stays and reimbursing claims for the specialized substance abuse services of non-American Indians and Alaska Natives. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for further information on PIHPs, Mental Health and Substance Abuse Services. Substance abuse services for non-American Indians and Alaska Natives must not be billed under CPT and HCPCS codes.

4.5 Service Limits

THCs may exceed the substance abuse treatment limits for American Indian and Alaska Native beneficiaries as long as the medical record and plan of care documents the medical necessity.

4.6 Noncovered Services

The following substance abuse services are not covered when provided through THCs:

- Emergency and non-emergency transportation
- Initial emergency screening and medical stabilization
- Acute medical detoxification services
- Medications prescribed in the management or treatment of methadone
- Room and Board

SECTION 5 – MENTAL HEALTH

Outpatient mental health services provided by physicians, clinical social workers, and clinical psychologists are covered. These services may include:

- Health assessment
- Psychiatric evaluation
- Psychological testing
- All other assessments and testing
- Case management
- Child therapy
- Crisis interventions
- Crisis residential services
- Intensive crisis stabilization services
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy
- Interpretation or explanation of data to family
- Medication administration
- Medication review
- Therapies (i.e., psychiatric occupational/recreational therapy) in a mental health treatment center are a covered service provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.

5.1 NONENROLLED PROVIDERS

Professional services provided by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns are covered but must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Individuals who meet Michigan licensure/certification requirements for social workers and psychologists may provide services.

5.2 AUTHORIZATION

Mental health services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of PIHPs/CMHSPs.

5.3 American Indian and Alaska Native Services

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health services directly from the THC. THC services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs may refer tribal members to the PIHP/CMHSP for mental health services not provided at the THC.

5.4 Non-American Indian Services

PIHPs/CMHSPs assume responsibility for community-based mental health and developmental disability services covered through Medicaid for non-American Indians. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for policies and procedures. Non-American Indian mental health services must not be billed under CPT or HCPCS codes.

5.5 Noncovered Services

Mental Health services that are **not** the responsibility of the THC are as follows:

- Home-based mental health services
- Nursing facility (NF) mental health monitoring
- Emergency and non-emergency transportation

SECTION 6 – ENCOUNTERS

THCs are eligible to receive an encounter (per visit) rate as reimbursement for Medicaid covered services provided at the THC for native and non-native Medicaid beneficiaries.

The IHS outpatient all-inclusive rate (AIR) is determined by the Centers for Medicare & Medicaid Services (CMS) and is published in the Federal Register. The FQHC encounter rate under the FQHC MOU is an alternative methodology that was based on the prospective payment system (PPS) outlined in section 1902(bb) of the Social Security Act.

6.1 DEFINITION

An encounter is a face-to-face visit between a Medicaid beneficiary and the THC provider of health care services who exercises independent judgment in the provision of Medicaid-covered services. The THC provider may be credited with no more than one face-to-face encounter with a given beneficiary per day, except when the beneficiary, after the first encounter, suffers a separate or different illness or injury requiring additional diagnosis or treatment.

For a service to be defined as an encounter, the Medicaid-covered service must be recorded in the patient's record.

6.2 SERVICES BUNDLED IN THE ENCOUNTER

Ancillary Medicaid services (e.g., labs, x-rays, injections, etc.) are included in the per visit encounter. These ancillary services are described as being provided incident to the office visit. For example, lab services billed under the physician's NPI number would not be considered a separate encounter.

Ancillary services provided at another facility are not bundled under the office visit encounter. For example, services provided by the local hospital are not included in the encounter.

SECTION 7 – BILLING

The Type 2 (Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number of the practitioner overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. The following providers may be reported in the attending provider field:

- Physicians (includes dentists, podiatrists, optometrists, and chiropractors)
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives
- Clinical Psychologists
- Clinical Social Workers
- Clinical Nurse Specialists
- Licensed Psychologists (Doctoral Level)
- Social Workers (Master's Level)
- Professional Counselors (Master's or Doctoral levels)
- Marriage and Family Therapists
- Limited Licensed Psychologists (Master's or Doctoral Level)

Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Type 2 (Organization) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

7.1 CLINICAL TRIALS

The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information.

All THC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. In addition, THC claims must include:

- A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)

- Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim.
- Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1.
  - HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study.
  - HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.

7.1.A. Reporting Non-Covered Services

Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.

7.2 Other Insurance

Billing instructions related to coordination of benefits are published in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. If payment received from other insurance exceeds the amount Medicaid would have paid, the THC must still submit a claim to Medicaid with the appropriate procedure code in order for the visit to be counted as an encounter.

7.3 Medicare and Medicaid Claims

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

7.4 Payer of Last Resort

The IHS is the payer of last resort for persons defined as eligible for contract health services under the regulations in 42 CFR, Part 36a, Subpart G, Section 36.61, notwithstanding any State or local law or regulation to the contrary.

7.5 Copayments

Medicaid copayments for chiropractic, dental, physician, podiatry and vision services are waived under the THC benefit as part of the reconciliation. (Refer to the General Information for Providers chapter for a list of services requiring copayments.)

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

7.6 Timely Filing Billing Limitation

The same timely filing billing limitations explained in the General Information for Providers Chapter of this manual pertain to encounters as well as claim submission.

7.7 Place of Service

Place of service codes are not applicable to institutional billing. However, if the THC performs a service that must be billed on the professional claim form within the clinic, THCs must use place of service (POS) code 07. For services provided outside the THC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

THC services provided to beneficiaries at the THC are reconciled annually, if applicable.

The THC may bill for covered services that are not provided at the THC. These services must be billed with the appropriate Place of Service (POS) code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual.

Services billed to Medicaid are subject to audit and verifications.

7.8 Billing for Maternity Care

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (THC and hospital). In order for the THC to be reimbursed for prenatal visits under the PPS methodology, the THC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology.

If the THC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

7.8.A. Billing Requirements for Group Prenatal Care Services

Centering Pregnancy™ group services will be reimbursed outside of the Prospective Payment System (PPS) or All-Inclusive Rate (AIR) methodology at the Medicaid fee screen reimbursement rates for these services. THCs should use appropriate Healthcare Common Procedure Coding System (HCPCS) codes as identified in the Billing & Reimbursement for Professionals chapter of this manual.

SECTION 8 – MEDICAID PAYMENTS, ANNUAL RECONCILIATION AND APPEALS

8.1 QUARTERLY PAYMENTS

Quarterly payments are made to the THC at the beginning of each quarter. The payment is based on an estimate of the difference between the amount the THC receives for Medicaid services from FFS claims, managed care encounters, and other third party payments (including Medicare) during the year and the amount due the center based on the THC encounter rate. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to THCs. The THC may request a change in the quarterly payment through the MDHHS HCRD.

8.2 INITIAL RECONCILIATION AND SETTLEMENT

An annual reconciliation, if applicable, ensures that reimbursement is made according to the payment option selected by the THC. The initial reconciliation and settlement is calculated approximately six months after the THC's fiscal year end. The number of encounters is determined from Medicaid fee-for-service (FFS) and managed care approved claims. Any difference between the THC rate and the amount paid to the THC from FFS and managed care payments, other insurance and quarterly payments is paid to or recovered from the THC. Future quarterly payments are adjusted based on the information in the initial reconciliation.

8.3 FINAL RECONCILIATION AND SETTLEMENT

A final reconciliation and settlement is calculated approximately one year after the THC's fiscal year end. This will allow time for all claims to clear the payment system.

8.4 APPEALS

A Medicaid provider has the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). The appeals process is outlined in MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended, and filed with the Secretary of State on May 19, 2016. Any questions regarding this appeal process should be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

SECTION 9 – ALTERNATIVE PAYMENT METHODOLOGY FOR PRESCRIPTIONS

All prescriptions will be reimbursed at the IHS per visit outpatient AIR determined annually by CMS and published in the Federal Register. Reimbursement at the AIR will be allowed for each prescription provided to Medicaid and Healthy Michigan Plan beneficiaries served at a THC or Tribal FQHC pharmacy. The AIR applies to encounters for both native and non-native beneficiaries.

9.1 ENCOUNTERS

There is no limit on the number of prescription encounters that may be reimbursed in a single day, and each prescription constitutes a separate encounter. The encounter rate includes dispensing services and drug costs. All THC and Tribal FQHC pharmacies are paid the encounter rate by Michigan Medicaid regardless of their method of purchasing. All drugs on the Michigan Pharmaceutical Product List (MPPL) and drugs with Medicaid prior authorization will be reimbursed the AIR. No drugs will be excluded from the AIR except for drugs on the Children's Special Health Care Services (CSHCS) drug list. All THCs and Tribal FQHC pharmacies must have a mechanism to dispense all necessary medications and, if a medication is not available, pharmacies must coordinate and transfer the prescription to a local pharmacy that carries the drug to minimize any disruption to the beneficiary. All other existing Medicaid policies and coverage limitations apply.

9.2 QUARTERLY PAYMENTS

MDHHS will adjudicate and reimburse the AIR for Medicaid FFS claims and cost-settle Medicaid Health Plan (MHP) and Integrated Care Organization (ICO) prescription encounters at an agreed upon frequency. A cost settlement payment is based on an estimate of the difference between (1) the AIR and (2) the amount the Tribal 638 facility receives for managed care encounters and third-party payments (including Medicare Part B covered drugs). Medicare Part D covered drugs will be excluded from AIR reimbursement. (Refer to the Coordination of Benefits Chapter for information on Medicare Part D coverage.)

When payment determination is made, correspondence will be sent to the THC or Tribal FQHC with overall reimbursement and the non-federal match due. If the THC or Tribal FQHC disagrees with the amount, the facility may request reconsideration within 14 calendar days of the date of the correspondence. Requests must be supported with sufficient details and examples for MDHHS to render a determination. (Refer to the Appeals subsection of this chapter for information on appealing an adverse action.)

URGENT CARE CENTERS

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SECTION 1 – GENERAL INFORMATION

An Urgent Care Center (UCC) is a medical clinic or office, not located in a hospital emergency department, whose purpose is to provide unscheduled diagnosis and treatment of illnesses for ambulatory beneficiaries requiring immediate medical attention for non-life-threatening conditions. It is expected that UCCs will provide access to a place of service (POS) more appropriate than a hospital emergency department for addressing non-emergency medical needs when a beneficiary's primary care provider (PCP) is not available.

1.1 STAFF CREDENTIALS

The UCC medical director must be a Michigan-licensed physician. The UCC medical director is responsible for the medical management of the UCC. All Medicaid-covered physician services must be performed by the physician, the physician's employee, or an employee of the same legal entity that employs the physician under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician assistant, nurse practitioner), as authorized by Public Act 368 of 1978 as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises.

1.2 HOURS OF OPERATION

UCCs must be open seven days a week, and include evening hours, weekends and holidays. Hours of operation must be posted in the facility. UCCs must accept walk-in patients of all ages during all hours the facility is open to see patients.

SECTION 2 - COVERED SERVICES

Unscheduled, non-emergency, medically necessary services that are a non-life threatening condition or injury or illness that can be treated appropriately in a UCC are Medicaid covered services.

Michigan Department of Health and Human Services (MDHHS) covered services are based on the level of care that can be appropriately rendered in an urgent care place of service.

MDHHS will not cover separate facility charges.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

All facilities must provide clinical documentation for services rendered and complete a discharge summary which must be sent to the appropriate PCP. If a beneficiary does not have a PCP, the facility must document assistance with arranging a medical home for follow-up care.

SECTION 3 – PROVIDER ENROLLMENT

Providers must be enrolled with Medicaid and have a valid Type 2 (Organization) National Provider Identifier (NPI) for MDHHS claim adjudication.

Claims must also include the appropriate Type 1 (Individual) NPI of the specific provider performing the service(s) as the rendering provider. A valid MDHHS-enrolled rendering provider number is required for claim adjudication. Providers must not enter a Type 2 (Organization) NPI as the rendering provider. The Organization NPI must be reported as the billing provider.

3.1 NPI EDITS

MDHHS NPI claim editing will be applied to attending, billing, referring, rendering and supervising providers, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

SECTION 4 – BILLING & REIMBURSEMENT

UCC providers must follow uniform billing guidelines using the professional CMS-1500 claim format or electronic Health Care Claim Professional (837) ASC X12N Version 5010 information. All providers are encouraged to bill electronically. Refer to the Billing & Reimbursement for Professionals chapter for additional CMS-1500 or 837P Professional claims submission and billing information.

If ancillary services are provided by UCC staff using hospital-owned equipment (i.e., done in the same building where urgent care is located), the hospital may bill that service on the institutional claim format for the technical service.

Reimbursement is based on the practitioner fee schedule. Services performed in a UCC are reimbursed at the non-facility rate based on the non-facility relative value unit (RVU). MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies. To avoid duplicate payments, UCC providers must submit only one non-facility service claim per beneficiary per DOS. Separate physician service claims should not be submitted.

4.1 COPAY REQUIREMENTS

A copayment may be required for office evaluation and management (E&M) visits for beneficiaries age 21 years and older.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

VISION

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SECTION 1 – GENERAL GUIDELINES AND REQUIREMENTS

The Michigan Department of Health and Human Services (MDHHS) contracts for the volume purchase of frames and lenses from an optical laboratory, referred to in this chapter as the contractor.

Vision providers (e.g., opticians, dispensing ophthalmologists, optometrists) must order frames and lenses from the contractor. A list of lenses is available in the MDHHS Vision Services Fee Schedule located on the MDHHS website. A list of available frames is available from the contractor, currently Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

Orders placed with the contractor must be postmarked no later than 30 days after the date of order. If orders are placed beyond the 30 days, the contractor returns the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

Procurement of contact lenses, low vision aids, and prosthetic eyes must be obtained from the vision provider's own source and are subject to prior authorization (PA) requirements as described in this chapter.

1.1 BENEFICIARY ELIGIBILITY AND COPAYMENTS

Providers must verify beneficiary eligibility prior to rendering services or ordering materials. If a beneficiary's eligibility expires prior to the date the material is delivered, reimbursement is made **only** if the beneficiary was eligible on the date the material was ordered by the vision provider and the date of order is used when billing. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

A copayment may be required for Medicaid beneficiaries age 21 and older for each separately reimbursable:

- Ophthalmological service performed by an optometrist or ophthalmologist; and
- Dispensing service for glasses or contact lenses billed by dispensing ophthalmologists or optometrists.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.2 PRIOR AUTHORIZATION

Some vision services and materials require PA before they can be rendered. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. A copy of the DCH-0893 and completion instructions can be found in the Forms Appendix of this manual. Complete and mail or fax the DCH-0893 to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.) PA requests must be postmarked no later than 30 calendar days after the date of order. If

beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, providers should make a photocopy of the completed form for the beneficiary file. Upon completion of the PA process, MDHHS returns one copy of the DCH-0893 to the provider.

An electronic copy of the DCH-0893 is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.3 Coding of Services

The American Medical Association's (AMA) Current Procedural Terminology (CPT) is the national coding standard for health care professional services. Vision providers must use CPT codes in effect on the date of service to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent certified in order to use many of these codes. All prescriptions or prescription orders must comply with state and federal laws. (Refer to the Pharmacy Chapter of this manual for additional information.)

Providers must use the International Classification of Diseases (ICD) for diagnostic coding of diseases, injuries, and conditions. Codes must be used at the highest level of specificity.

Healthcare Common Procedure Coding System (HCPCS) is a system developed by the Centers for Medicare & Medicaid Services (CMS) to report materials, supplies, and certain services not covered by the CPT codes. HCPCS codes are to be used when applicable.

1.4 Medicare

All vision services are subject to editing for Medicare coverage. MDHHS reimburses vision providers for coinsurance and deductible amounts on Medicare-approved claims up to Medicaid's reimbursement limit.

If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses or frames through the volume purchase program.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5 Contractor Guarantee

Frames and lenses furnished by the contractor are guaranteed for 90 days. If any material is found to be unsatisfactory due to contractor error or defective workmanship or materials, the materials and work order form should be returned to the contractor. The contractor is required to correct, adjust, or replace the materials.

If the vision provider supplies the contractor with incorrect specifications that results in eyeglasses being fabricated which the beneficiary cannot use, the vision provider is responsible for payment to the contractor for the remake. The contractor may not charge the vision provider more than what they would charge MDHHS for the remake. MDHHS does not pay for the remake (e.g., eyeglasses, lenses, or frames) due to vision provider error.

1.6 Complaint Process

To resolve problems (such as an overdue shipment, error in an order, or defective workmanship), vision providers should first contact the contractor.

If the lenses and/or frames are not received from the contractor within 21 days from the date they were ordered, vision providers are responsible for contacting the contractor to determine the cause of the delay.

If difficulties are encountered with the contractor in resolving a problem, vision providers should call the Vision Contract Manager. (Refer to the Directory Appendix for contact information.) Vision providers must be prepared to report the beneficiary's name and Medicaid ID number, and a detailed explanation of the problem(s) they have experienced.

MDHHS reviews the complaint, takes necessary action to correct the problem, and notifies the vision provider of the resolution.

SECTION 2 – DIOPTER CRITERIA

2.1 INITIAL LENSES

Initial lenses are considered to be the first prescription lenses ever worn by a person regardless of how they were obtained (e.g., through Medicaid, other insurance, or private pay). Initial lenses are a Medicaid benefit and do not require PA if the following minimum diopter criteria are met:

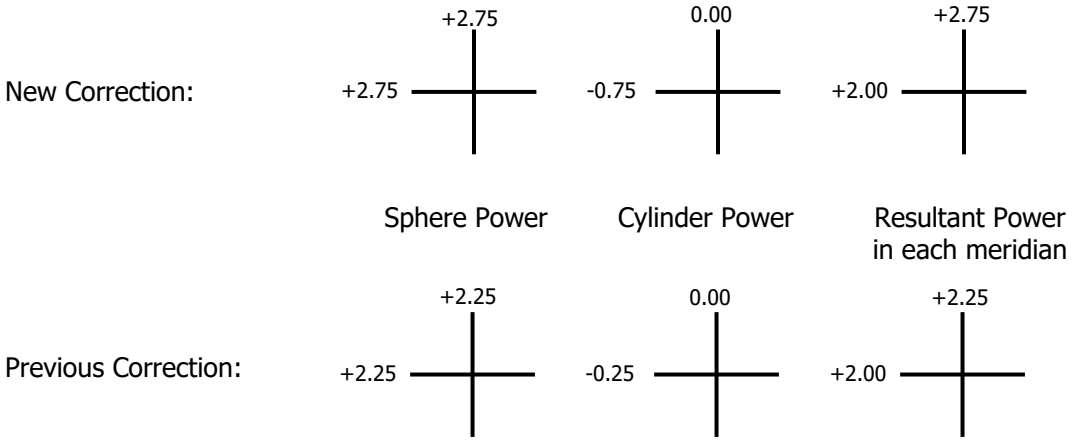
Age Group 42 Years and Younger	
▪ 0.50D myopia ▪ 0.50D astigmatism	▪ 0.75D anisometropia ▪ 0.75D hyperopia

Age Group 43 Years and Older	
▪ 0.50D myopia ▪ 0.50D astigmatism ▪ 0.75D anisometropia	▪ 0.50D hyperopia ▪ 0.50D presbyopia

2.2 SUBSEQUENT LENSES

Regardless of age group, subsequent lenses are medically necessary lenses that are provided after initial lenses. Subsequent lenses are a Medicaid benefit and do not require PA if there is a change in the refractive error of 0.75D or more in the meridian of greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more. These lenses must also meet minimum dioptric criteria as specified above. The change need only be present in one eye.

The following example illustrates how this requirement is assessed for a new correction (+2.75-0.75 ax 092) and a previous correction (+2.25-0.25 ax 090). The dioptric power in each meridian can be portrayed in the form of cross diagrams.



This is an example of where the change in dioptric power for subsequent lenses has not been met. Note that the resultant powers in the vertical meridians of the "new" and "previous" correction are +2.75 and +2.25 respectively. There is only a 0.50D change in the vertical meridian and no change in the horizontal.

For periods greater than 24 months from the date of the previous prescription, subsequent lenses may be ordered for diopter changes less than those specified above.

SECTION 3 – SERVICES

This section provides information on both Medicaid covered and noncovered services.

3.1 DIAGNOSTIC SERVICES

In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, and within the scope of current medical practice and Medicaid limitations. The prescribing optometrist or ophthalmologist is held responsible if they order excessive or unnecessary services, regardless of who actually renders the services. The prescribing optometrist or ophthalmologist may be subject to corrective action related to these services, including recovery of funds.

*Documentation Guidelines for Evaluation and Management Servi*ces, as described in the latest version developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.

Eye Examinations	▪ A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate CPT/HCPCS procedure codes for routine eye exam and applicable ICD diagnosis codes. ▪ Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, or sudden onset of abnormal ocular conditions. (Use appropriate CPT/HCPCS procedure codes.)
Glaucoma Screenings	Glaucoma screenings are covered without PA on an annual basis for beneficiaries who: ▪ Have no ocular complaints or prior history of glaucoma and who have diabetes; ▪ Have a family history of glaucoma; or ▪ Are African-American, age 50 or older. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. Use the appropriate CPT/HCPCS procedure code for glaucoma screening and the applicable ICD diagnosis code. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening code should not be used. The procedure code which best describes the visit should be selected from the CPT Evaluation and Management (E/M) codes or General Ophthalmological procedure codes.

3.2 Dispensing Services

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

3.3 Nursing Facility Beneficiaries

Covered and noncovered vision services, as well as PA requirements, apply to vision services provided to beneficiaries residing in a nursing facility (NF).

Performance of vision services (except replacement of a frame part for eyeglass repair) must be upon the written request of the beneficiary, a member of the beneficiary's family, or other beneficiary representative and upon the written order of the beneficiary's attending physician (MD, DO) prior to the date of the vision provider's visit.

If service is provided in the NF, a copy of the request and written order must be retained by the facility as part of the beneficiary's record.

Vision services are not considered a part of the facility's per diem rate. The vision provider or contractor must bill MDHHS for vision services rendered.

No additional payments are made to vision providers for a visit(s) to the NF. Appropriate procedure codes must be utilized.

3.4 Ophthalmic Frames and Lenses

A complete pair of eyeglasses is a Medicaid benefit and does not require PA when:

- The eyeglasses being prescribed are the beneficiary's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames are unusable.
- A previously used frame requires oversized lenses. (Oversized lenses are not a Medicaid benefit, therefore, a complete pair of eyeglasses must be ordered.)
- Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a Medicaid benefit.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider or beneficiary elects not to send the frames to the contractor or the contractor feels that the previously used frames will break or otherwise be damaged during lens insertion.

- The beneficiary's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded Medicaid limits which are:
  - For beneficiaries age 21 and over, one pair of replacement eyeglasses per year.
  - For beneficiaries under age 21, two pair of replacement eyeglasses per year.

  One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

The DCH-0893 must be used when ordering frames and/or lenses. A copy of the form and instructions for completing the form are available in the Forms Appendix of this manual and on the MDHHS website. (Refer to the Directory Appendix for website information.) These orders must be sent directly to the contractor. Orders may be mailed, faxed, or entered directly online at the contractor's website. (Refer to the Directory Appendix for contact information. The contractor must be contacted directly to register for on-line access.) The contractor fills the vision provider's order in accordance with the lens and frame specifications indicated on the DCH-0893. The order form is returned to the provider if the eligibility information is not completed.

Procedures identified as requiring PA must first receive approval from the MDHHS Program Review Division. (Refer to the Prior Authorization subsection in this chapter for instructions on obtaining PA.)

The contractor monitors orders to assure that Medicaid replacement limitations, diopter criteria, and PA requirements are being maintained. The contractor returns an order if the order exceeds the replacement limits, does not meet diopter criteria, or requires PA.

The contractor bills MDHHS for the frames and/or lenses ordered by vision providers. Vision providers subsequently bill for a dispensing service for dispensing the frames and/or lenses.

If the beneficiary has other insurance that covers frames and/or lenses, the material may still be obtained through the contractor. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual when billing for the dispensing service if other insurance is involved.)

3.4.A. LENSES

Lenses must conform to the latest edition of the *American National Standard Recommendations for Prescription Ophthalmic Lenses*.

Plastic and glass lenses are a Medicaid benefit. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

- Plastic and glass bifocals are available in Round 22, FT-28, FT-35, and Executive style.
- Plastic and glass trifocals are available in FT-7x28 segments.

Photochromic, Tinted and Dyed Lenses	PA is required for these lens features. Appropriate documentation of medical necessity must be attached to the DCH-0893 when submitted to the MDHHS Program Review Division.
Polycarbonate Lenses	For beneficiaries under age 21, polycarbonate lenses may be inserted into any covered Medicaid frame and do not require PA. For beneficiaries 21 and over, polycarbonate lenses are a Medicaid benefit when lenses are inserted into a safety frame marked "Z 87" or "Z 87-2" or if prior authorized.

Oversized lenses, no-line, or progressive style multi-focals are not Medicaid benefits.

3.4.B. Ophthalmic Frames

Frames must conform to the latest edition of the *American National Standard Requirements for the Dress Ophthalmic Frames*.

Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor, and a list of available frames is available from the contractor. (Refer to the Directory Appendix for contact information.) The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames.

Vision providers must offer a beneficiary the opportunity to select a frame from a minimum of 100 authorized frame samples. Additionally, a vision provider must offer beneficiaries the contractor's brochure of frames which includes all available styles so beneficiaries can select from more than the vision provider's inventory of sample frames. A vision provider who fails to comply with these requirements is subject to termination of enrollment in Medicaid.

If a frame manufacturer discontinues production of a frame that is listed as a benefit, vision providers may utilize the discontinued frame from their sample kit. If lenses are required, they must be ordered from the contractor. Submit the DCH-0893 to the MDHHS Program Review Division for approval. (Refer to the Directory Appendix for contact information.)

Safety Frames	Safety frames are a Medicaid benefit. A list of authorized safety frame styles is available from the contractor. These frames conform to ANSI Z87.1-2003 standards, and samples can be purchased from the contractor at contract prices. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2".
Frame Repairs	Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.

3.4.C. Subsequent Lenses Placed in Previously Used Frames

Subsequent lenses that are to be placed in a beneficiary's previously used frame are a Medicaid benefit and do not require PA. Previously used frames are defined as ophthalmic frames in which the beneficiary has had previous corrective lenses incorporated and which were previously worn.

All noncontract previously used frames require PA.

To order subsequent lenses for insertion into a previously used frame, vision providers must complete the DCH-0893, indicating all information necessary for proper fabrication. Vision providers have the option of having the contractor insert the lenses, in which case the provider must supply the previously used frame to the contractor, or inserting the newly fabricated lenses into the frames in their office.

If the previously used frames are sent to the contractor for lens insertion, the contractor is required to fabricate the lenses and mail the frames and lenses to the vision provider within nine working days after receiving the frames. If a special prescription requires more than nine working days to complete, the contractor must notify the vision provider. If the provider does not receive the materials within three weeks from the date the order was sent, they should contact the contractor.

If the vision provider or beneficiary elects not to send the previously used frames as might be requested by the contractor, or if the contractor feels that the previously used frames may break or otherwise be damaged during lens insertion, the vision provider is requested to order a complete pair of eyeglasses.

If frames are sent to the contractor, either at the contractor's request or the vision provider's preference, the vision provider is responsible for paying the postage necessary to ship the frames. Also, vision providers are responsible for paying for frames lost or damaged in transit.

If a previously used frame requires lenses that are not a Medicaid benefit (e.g., oversize lenses), a complete pair of eyeglasses that are a benefit must be ordered.

3.4.D. Replacement or Repair

Eyeglasses	Eyeglass repairs are a separately reimbursed service when the repair is considered major (e.g., reinsertion of a lens, repair of a sheared screw, shortening or replacing temples, etc.) and when the glasses are deemed repairable. Minor repairs (e.g., insertion of screw, adjustments of nose pads or temples, etc.) that occur as a result of the beneficiary's typical wear patterns are not separately reimbursed. The appropriate HCPCS code(s) must be reported for the component part that is being replaced. The reason for the repair must be documented in the beneficiary's file and made available upon request. If a provider determines that eyeglasses are repairable, the provider must guarantee the repair for a minimum of 30 days. Subsequent repair for the same issue within 30 days is the responsibility of the provider. If replacement eyeglasses are needed within the 30 day time frame following a repair, the provider must return the reimbursement received for the repair to MDHHS. Eyeglasses that are broken beyond repair may be eligible for replacement by the contractor. Eyeglass replacement requires prior authorization if replacement limits have been exceeded.
Lenses Only	Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. It does not require PA. Vision providers must order the lens(es) directly from the contractor. For periods greater than 24 months from the date of the previous prescription when ordering subsequent lenses or complete eyeglasses, see Subsequent Lenses subsection above for appropriate diopter criteria.
Frames Only	Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit. The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.

3.4.E. Two Pairs of Eyeglasses

Two pairs of single vision eyeglasses (one for near visual tasks and the other for distance visual tasks) are a Medicaid benefit in either of the following instances:

- When the beneficiary has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.
- When the beneficiary's physical condition does not allow bifocal usage.

PA is required when requesting two pairs of eyeglasses. Appropriate documentation must be attached to the DCH-0893 and submitted to the MDHHS Program Review Division.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a Medicaid benefit.

3.4.F. Nondeliverable Eyeglasses

If a beneficiary fails to return to the vision provider for dispensing of eyeglasses, the vision provider should make every effort to locate the beneficiary, including contacting the local MDHHS office in the beneficiary's area.

If the beneficiary still cannot be located, the eyeglasses should be sent to the local MDHHS office (or local nonprofit agency if the MDHHS office refuses to accept them) in the beneficiary's area within 90 days of placing the order with the contractor. Do not send the nondelivered lenses and/or frames to MDHHS unless requested to do so by MDHHS.

To bill for dispensing, the provider must use the date of order for the lenses and/or frames.

Medicaid does not reimburse vision providers for postage and handling.

3.4.G. Eyeglass Case

One eyeglass case for every complete pair of eyeglasses ordered is a Medicaid benefit and must be provided by the contractor. Vision providers cannot bill for eyeglass cases.

3.5 Low Vision Services

Evaluation	A low vision evaluation is a benefit when the beneficiary presents with moderate visual impairment, severe visual impairment, or profound visual impairment. Under these conditions, a low vision evaluation does not require PA. This evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of beneficiary, and advice to family (if appropriate). The CPT E/M or General Ophthalmological procedure code which best describes this service should be utilized.

Aids	High add bifocals do not require PA. For high add bifocals, complete the DCH-0893 and submit to the contractor. The prescription and fitting of low vision optical aids (such as telescopes, microscopes, and certain other low vision aids) require PA. Only basic and essential low vision aids are a Medicaid benefit. The Provision of Low Vision Services and Aids Support Documentation (MSA-0891) form outlines the information required when requesting PA for low vision services and aids. A sample of this form is provided in the Forms Appendix. It can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.) This form must be attached to DCH-0893 and submitted as part of the PA process. (Refer to the Prior Authorization subsection above.) Reimbursement for a low vision aid is based on the manufacturer's charge for the aid plus a professional fee. Procurement of the low vision aid is done through the vision provider's own source. The professional fee includes procurement, verification, and fitting of the aid. Only an enrolled optometrist or a dispensing ophthalmologist can bill for a low vision aid.
Rehabilitative Services	Low vision rehabilitative services include instructions, training, and assistance to the beneficiary in the most effective use of the low vision aid. Documentation for these services should be included when requesting the low vision aid.

3.6 Contact Lenses

3.6.A. Evaluation

A comprehensive contact lens evaluation is a Medicaid benefit when the beneficiary presents with one of the following conditions (use appropriate HCPCS comprehensive contact lens evaluation code):

- Aniridia
- Anisometropia or Antimetropia (of two diopters or greater that results in Aniseikonia)
- Aphakia
- Irregular cornea
- Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- Other conditions which have no alternative treatment (e.g., Aniseikonia with documentation and severe Keratoconjunctivitis sicca)

3.6.B. Prescription and Fitting

The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries who are under six years of age with a diagnosis of aphakia.

3.6.B.1. PRESCRIPTION

The prescription for contact lenses requires the complete description of contact lens specifications. The following must be included on a prescription for contact lenses:

- complete description of the contact lens(es) parameters
- material of the contact lens(es)
- manufacturer of the contact lens(es)
- material discard and replacement schedule
- number of lenses required to provide a one-year supply
- prescription expiration date

3.6.B.2. FITTING

The fitting of the contact lens(es) must include:

- determination of appropriate initial contact lens parameters based on clinical observation, and measurements of the eye with or without a trial (sample) contact lens.
- a trial or adaption period of one to three months, including a fitting warranty that provides for adjustments in the contact lens parameters either by exchange or by modification of existing materials.

  Note: Certain custom contact lens designs may not be warranted by the manufacturer. This type of custom contact lens design will be considered on a case-by-case basis. The provider must provide a detailed explanation of need, initial cost, and potential re-fitting cost.
- instruction of proper insertion, removal, disinfection, and care of the contact lens(es).
- initial supply of contact lenses, storage case, and solutions sufficient to last until the fitting is complete.

3.6.C. REPLACEMENT AND SUPPLIES

Procurement of contact lenses is to be done through the vision provider's own source.

The Documentation of Medical Necessity for the Provision of Contact Lenses form (MSA-0892) outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.)

This form must be attached to the Vision Services Approval/Order form (DCH-0893) and submitted to MDHHS as part of the PA process. (Refer to the Prior Authorization subsection in this chapter for additional information.)

Requests for contact lens replacements due to loss or damage will require PA and will be reviewed on an individual basis.

Except as previously indicated, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

3.7 Strabismus and Amblyopia Examination

Strabismus and amblyopia examinations (sensorimotor examination) are Medicaid benefits and do not require PA.

3.8 Orthoptics and Pleoptics Training

Orthoptics and Pleoptics Training	Orthoptics and Pleoptics (O & P) training is a Medicaid benefit only when there is a diagnosis of one of the following conditions: ▪ Amblyopia ▪ Esotropia ▪ Exotropia ▪ Heterotropia ▪ Strabismus ▪ Ocular Motor and Fusion Dysfunction PA is not required for O & P training for beneficiaries under age 21. PA is required for beneficiaries age 21 and older for O & P training. When requesting PA, the following documentation must be attached to the DCH-0893 and submitted to the Program Review Division: ▪ Visual acuity, each eye, with best spectacle correction; ▪ Magnitude and direction of the subjective and objective angle of strabismus at distance and near; ▪ Refractive error of each eye; ▪ Degree of fusion; ▪ History of strabismus, including onset, duration, prior treatment; and ▪ Other relevant information. In addition to the above documentation, a detailed plan indicating the training procedures and equipment to be employed, frequency of office visits, home training aids, and prognosis must be attached to the DCH-0893. This training plan may be authorized for a period of up to three calendar months. O & P training is limited to a maximum of 13 visits within the first three calendar months of therapy without PA. PA will be required for additional necessary visits. If continued training beyond the period that was authorized is necessary, a new request for PA must be submitted with the following information: ▪ Update of the above-listed items; ▪ Report of the results of previous training; and ▪ Indication for further treatment with a detailed plan.

Orthoptic Training Aids	Orthoptic training aids are a Medicaid benefit when incorporated in an orthoptics or pleoptics training plan (as described above) and require PA. The following documentation must be included with the vision provider's detailed plan when requesting the purchase of an aid: ▪ How the aid is to be used; ▪ Complete description of the aid; ▪ Name of the manufacturer; and ▪ Manufacturer's charge. Reimbursement for a training aid is based on the manufacturer's charge to the vision provider plus a professional fee. The professional fee includes procurement, instruction in use, and fitting when applicable. Procurement of the training aid is done through the vision provider's own source. Purchase of orthoptic training aids must be billed only by an enrolled optometrist or dispensing ophthalmologist.

3.9 Prosthetic Eyes

A prosthetic eye (plastic/custom) or shell is a Medicaid benefit and does not require PA.

For an enlargement or reduction of an ocular prosthesis, PA is required. PA is also required when requesting a prosthesis other than a plastic/custom eye. When requesting PA, the DCH-0893 should be completed, with documentation attached, and submitted to the MDHHS Program Review Division. Procurement of the prosthesis should be obtained from the provider's own source.

Reimbursement for a prosthesis is made on a per case basis which includes, but is not limited to:

- Trial fitting
- Supply of prosthesis
- Solutions
- Training in insertion and removal
- Instruction in care
- Subsequent office visits to achieve maximum wearing time and optimal cosmetic fit
- Any necessary modification during the adaptation period of six months

ACRONYM APPENDIX

Acronym	Meaning
3M™ APR-DRG	3M™ All Patient Refined Diagnosis Related Groups
AA	Anesthesiologist Assistant
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAAHC	Accreditation Association for Ambulatory Health Care
AAP	American Academy of Pediatrics
AAPD	American Academy of Pediatric Dentistry
AAR	Access Assessment and Referral
ABA	Applied Behavior Analysis
ABAS-III	Adaptive Behavior Assessment System-III
ABC	American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.
ABGC	American Board of Genetic Counseling
ABI	Applied Behavioral Intervention; Acquired Brain Injury
ABLLS-R	Assessment of Basic Language and Learning Skills - Revised
ABMG	American Board of Medical Genetics
ABR	Auditory Brainstem Response
ACA	Affordable Care Act
ACBIS	Academy of Certified Brain Injury Specialists
ACD	Augmentative communication device
ACEs	Adverse Childhood Experiences
ACHC	Accreditation Commission for Health Care
ACIP	US Public Health Service Advisory Committee on Immunization Practices
ACT	Assertive Community Treatment
ACVREP	Academy for Certification of Vision Rehabilitation and Education Professionals
ADA	American Dental Association; Americans with Disabilities Act; American Diabetes Association
ADCES	Association of Diabetes Care and Education Specialists

Acronym	Meaning
ADHD	attention deficit hyperactivity disorder **(added 4/1/2025)**
ADI-R	Autism Diagnostic Interview - Revised
ADL	Activities of Daily Living
ADOS-2	Autism Diagnostic Observation Schedule - Second Edition
AEP	auditory evoked potential
AER	Administrative Expense Report
AFC	Adult Foster Care
AFC/HFA	Adult Foster Care Facility/Home for the Aged
AFLS	Assessment of Functional Living Skills
AFO	Ankle-Foot Orthosis
AHI	Apnea-Hypopnea Index
AHRQ	Agency for Healthcare Research and Quality
AI	Assessment Indicator
AICPA	American Institute of Certified Public Accountants
AIMS	Attachment-Interaction-Mastery-Support
AIR	All-Inclusive Rate
ALD	Alternative Listening Device
ALMB	Additional Low Income Medicare Beneficiary
ALS	Advanced Life Support
ALTE	Apparent Life Threatening Event
AMA	American Medical Association; against medical advice
ANSI	American National Standards Institute
AO	Accreditation Organization
AOA	American Osteopathic Association
AOD	alcohol and other drug
APA	American Psychological Association
APC	Ambulatory Payment Classification

Acronym	Meaning
APHA	American Public Health Association
API	Active Pharmaceutical Ingredients
APIT	Authority to Practice Interjurisdictional Telepsychology
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
APTA	American Physical Therapy Association
AQAR	Administrative Quality Assurance Review
ARD	Assessment Reference Date
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Center
ASD	Autism Spectrum Disorder
ASHA	American Speech-Language-Hearing Association
ASM	American Society for Microbiology; Adult Services Manual
ASQ	Ages and Stages Questionnaire
ASQ-SE	Ages and Stages Questionnaire – Social-Emotional
ASW	adult services worker
ATD	Assistive Technology Device
ATP	Assistive Technology Professional
ATR-BC	Registered Art Therapist – Board Certified
AUAM	Ambulatory Uterine Activity Monitor
AUD	Alcohol Use Disorder
BACB	Behavioral Analyst Certification Board
BAHD	Bone Anchored Hearing Device
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctoral

Acronym	Meaning
BCCCP	Breast and Cervical Cancer Control Program
BCCHPS	Bureau of Children's Coordinated Health Policy and Supports
BHT	Behavioral Health Treatment
BICROS	Bilateral Contralateral Routing of Signals
BIPA	Section 702 of the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act.
BIS	Brain Injury Services
BLRV	blood lead reference value
BLS	Basic Life Support
BMI	Body Mass Index
BMP	Benefits Monitoring Program
BOP	bleeding on probing
BPHASA	Behavioral and Physical Health and Aging Services Administration
BPS	Behavioral and Psychological Services
BRUE	Brief Resolved Unexplained Event
BSBP	Bureau of Services for Blind Persons
BSN	Bachelor of Science in Nursing
BSW	Bachelor of Social Work
BTP	Behavior Treatment Plan
BTPRC	Behavior Treatment Plan Review Committee
BY	Base Year
C3 Project	Community Health Worker Core Consensus Project
C4S	Caring for Students
CAA	Council on Academic Accreditation; Care Area Assessment
CADC	Certified Alcohol and Drug Counselor
CAFAS	Child and Adolescent Functional Assessment Scale
CAH	Critical Access Hospitals

Acronym	Meaning
CAHCP	Child and Adolescent Health Center and Program
CALOCUS	Child and Adolescent Level of Care Utilization System
CAMTS	Commission on Accreditation of Medical Transport Systems
CAP	College of American Pathologists
CAPD	Continuous Ambulatory Peritoneal Dialysis (hospital)
CARES	Coronavirus Aid, Relief, and Economic Security Act of 2020
CARF	Commission on Accreditation of Rehabilitation Facilities
CBC	Complete Blood Count
CBIS	Certified Brain Injury Specialist
CBSA	Core Based Statistical Area
CC PPS-1	certified clinic prospective payment system
CCA	Care Coordination Agreement
CCBHC	Certified Community Behavioral Health Clinic
CCI	Child Caring Institution
CDC	Centers for Disease Control and Prevention
CDL	Commercial Driver's License
CDT	Current Dental Terminology
CENA	Competency Evaluated Nurse Aide
CEPI	Center for Educational Performance and Information
CF	Cystic Fibrosis
CFR	Code of Federal Regulations
CFY	Clinical Fellowship Year
CHAMPS	Community Health Automated Medicaid Processing System
CHAP	Community Health Accreditation Program
CHI	Centering Healthcare Institute
CHIP	Children's Health Insurance Program
CHPL	Certified Health IT Product List

Acronym	Meaning
CHR	Community Health Representative
CHW	Community Health Worker
CIP	Capital Interim Payment
CKD	Chronic Kidney Disease
CLIA	Clinical Laboratory Improvement Amendments
CLS	Community Living Supports
CMC TCM	Children with Medical Complexity – Targeted Case Management **(added per bulletin MMP 24-61)**
CMCF	County Medical Care Facilities
CMCFSP	County Medical Care Facilities Special Payments
CMCS	Center for Medicaid and CHIP Services **(added 4/1/2025)**
CMHC	Community Mental Health Center
CMHP	Child Mental Health Professional
CMHSP	Community Mental Health Services Program
CMN	Certificate of Medical Necessity
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nurse Aide
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
CNS	Clinical Nurse Specialist
COA	Council on Accreditation of Services for Families and Children
COB	Coordination of Benefits
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure
CPH	Community Public Health
CPRC	Certified Peer Recovery Coach

Acronym	Meaning
CPS	Children's Protective Services
CPSS	Certified Peer Support Specialist
CPT	Current Procedural Terminology
CQAR	Clinical Quality Assurance Review
CR	Cardiac Rehabilitation
CRNA	Certified Registered Nurse Anesthetist
CROS	Contralateral Routing of Signals
CRP	Collaborative Remediation Project
CRT	Cognitive Rehabilitation Therapy
CRTS	Certified Rehabilitation Technology Supplier
CSHCS	Children's Special Health Care Services
CSW	Certified Social Worker
CT	Computerized Axial Tomography
CTLSO	Cervical-Thoracic-Lumbar-Sacral Orthosis
CTS	Community Transition Services
CWP	Children's Home and Community Based Services Waiver Program
CY	Current Year
DABS	Diagnostic Adaptive Behavior Scale
DAS-II	Differential Ability Scales-II
DCO	designated collaborating organization
DD	Developmental Disabilities
DDS	Dentist
DEA	Drug Enforcement Administration
DEAP	Diabetes Education Accreditation Program
DECA	Devereux Early Childhood Assessment
DEG	Data Exchange Gateway
DESI	Drug Efficacy Study Implementation

Acronym	Meaning
DHP	Dental Health Plan
DIFS	Department of Insurance and Financial Services
DIT	Directed In-Service Training
DKU	Diabetes and Kidney Unit [Michigan Department of Health and Human Services, Public Health Administration (PHA)]
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies
DMP	Document Management Portal
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Doctor of Podiatric Medicine
DPNA	Denial of Payment for New Admissions
DPO	Designated Provider Organization
DPOA	Durable Power of Attorney
DPOC	Directed Plan of Correction
DPP	Diabetes Prevention Program [Centers for Disease Control and Prevention]
DPRP	Diabetes Prevention Recognition Program [Centers for Disease Control and Prevention]
DPSCD	Detroit Public Schools Community District
DPT/CSAT	Division of Pharmacologic Therapies/Center for Substance Abuse Treatment
DQ	Developmental Quotient
DRG	Diagnosis Related Group
DSC	Direct service claiming
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSME	Diabetes Self-Management Education

Acronym	Meaning
DT	Dental Therapist
DTMB	Department of Technology, Management & Budget
DTT	Discrete Trial Training
DUB	Designated Unavailable Beds
DUR	Drug Utilization Review
E/M	Evaluation and Management
EAA	Environmental Accessibility Adaptations
EBG	Evidence-Based Guidelines
EBP	evidence-based practice
ECG	Electrocardiogram
ECR	Electronic Cost Report
ED	Emergency Department
EDI	Electronic Data Interchange
EEG	Electroencephalogram
EFL	Essential for Living
EFT	Electronic Funds Transfer
EGrAMS	Electronic Grants Administration and Management System
EH	eligible hospital (NOTE: Term applies to EHR Incentive Program only.)
EHR	Electronic Health Record
EIBI	Early Intensive Behavioral Intervention
EIN	Federal Employee ID number
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Active Labor Act
EOAE	Evoked Otoacoustic Emissions
EOB	Explanation of Benefit
EP	eligible professional (NOTE: Term applies to EHR Incentive Program only.)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment

Acronym	Meaning
ERP	Education Recognition Program
ESO	Emergency Services Only
ESRD	End Stage Renal Disease
ESR	Erythrocyte Sedimentation Rate
ESV	electronic service verification
EVS	Eligibility Verification System
EVV	Electronic visit verification
F/T	Full Time
FAO	Facility/agency/organization
FAP	Food Assistance Program
FAQ	frequently asked question
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FICA	Federal Insurance Contributions Act
FMAP	Federal Medical Assistance Percentage
FNP	Family Nurse Practitioner
FOC	Freedom of Choice
FPL	Federal Poverty Level B67
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
FTE	Full-Time Equivalent
FYE	Fiscal Year End
GAAS	Generally Accepted Auditing Standards
GAF	Global Assessment of Functioning
GDM	gestational diabetes mellitus
GED	General Educational Development; General Education Diploma

Acronym	Meaning
GLAD-PC	Guidelines for Adolescent Depression in Primary Care
GME	Graduate Medical Education
GPS	Global positioning service
HAA	Hospital Access Agreement
HBP	Hospital Based Provider
HBsAG	Hepatitis B Surface Antigen tests
HBV	hepatitis B virus
HCAC	Health Care Acquired Condition
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
HCRD	Hospital and Clinic Reimbursement Division (Michigan Department of Health and Human Services)
HCV	Hepatitis C virus
HDM	Home Delivered Meals
HELP	Hawaii Early Learning Profile
HFA	Home for the Aged
HFCWO	High Frequency Chest Wall Oscillation
HHA	Home Health Agency
HHCS	Home health care services
HHCT	Health Home Care Team
HHP	Health Home Partner; Health Home Provider
HHS	Health & Human Services (U.S. Department of)
HICN	Health Insurance Claim Number
HIE	Health Information Exchange; Hypoxic-Ischemic Encephalopathy
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HIS	Health Information System
HIT	Health Information Technology

Acronym	Meaning
HITECH	Health Information Technology for Economic and Clinical Health Act
HKAFO	Hip-Knee-Ankle-Foot Orthosis
HKD	Healthy Kids Dental
HLTCU	Hospital Long Term Care Unit
HMO	Health Maintenance Organization
HMP	Healthy Michigan Plan
HRSA	Health Resources and Services Administration
HSW	Habilitation Supports Waiver
HUAM	Home Uterine Activity Monitor
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
IBCLC	Internationally Board Certified Lactation Consultant
IBCLE	International Board of Lactation Consultant Examiners
ICA	Indigent Care Agreement
ICCD	International Center for Clubhouse Development (d/b/a Clubhouse International)
ICCW	Intensive Care Coordination with Wraparound
ICD	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities [previously known as Intermediate Care Facility for the Mentally Retarded (ICF/MR)]
ICO	Integrated Care Organization
ICR	Intensive Cardiac Rehabilitation
ICSS	Intensive Crisis Stabilization Services
ID	Identification
IDA	Infant-Toddler Developmental Assessment
IDD	Intellectual/Developmental Disabilities
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IDTF	Independent Diagnostic Testing Facilities

Acronym	Meaning
IE	Independent Employment
IECMHC	Infant and Early Childhood Mental Health Consultation **(added 4/1/2025)**
IEP	Individualized Education Program
IFDSH	Indigent Fund Disproportionate Share Hospital
IFSP	Individualized Family Service Plan
IGT	Intergovernmental Transfer
IHCP	Individualized Health Care Plan
IME	Indirect Medical Education
INS	Immigration and Naturalization Services (INS)
IOP	Intensive outpatient
IPOS	Individual Plan of Service
IQ	Intelligence Quotient
IRA	Imminent Risk Assessment
IRS	Internal Revenue Service
IS	Intensity of Service
ISD	Intermediate School District
ITFI	Infant-Toddler Family Instrument
IV	Intravenous; Indigent Volume
IVR	Interactive Voice Response
KAFO	Knee-Ankle-Foot Orthosis
KDE	Kidney Disease Education
LARA	Licensing and Regulatory Affairs (Department of)
LARC	Long Acting Reversible Contraceptive
LBSW	Licensed Bachelor of Social Work
LCD	Local Code Determination
LEA	Local Education Agency
LEIN	Law Enforcement Information Network

Acronym	Meaning
LEEP	Loop Electrosurgical Excision Procedure
LHD	Local Health Department
LIF	Low-Income Families
LLBSW	Limited License Bachelor of Social Work
LLMSW	Limited License Master of Social Work
LLP	Limited Licensed Psychologist
LMSW	Licensed Master of Social Work
LOA	Leave of Absence
LOC	Level of Care
LOCD	(Michigan Medicaid Nursing Facility) Level of Care Determination
LOCM	Low Osmolar Contrast Material
LOCUS	Level of Care Utilization System
LP	Licensed Psychologists
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LRD	Lifetime Reserve Days
LSD	Local School District
LSO	Lumbar-Sacral Orthosis
LTACH	Long Term Acute Care Hospital
LTC	Long Term Care
LTE	Less Than Effective
LTSS	Long Term Services and Supports
MA	Medicaid
MAC	Monitored Anesthesia Care; Maximum Allowable Cost; Master Addictions Counselor
MACI	Medicaid Access to Care Initiative
MAER	Medicaid Allowable Expenditure Report
MAPS	Michigan Automated Prescription System

Acronym	Meaning
MAT	Medication-Assisted Treatment
MBI	Medicare Beneficiary Identifier
MCBAP	Michigan Certification Board for Addiction Professionals
MCC	Managed Care Carriers
MCF	Medical Care Facility
MCI	Michigan Children's Institute
MCIR	Michigan Care Improvement Registry
MCL	Michigan Compiled Law
MCLFS	Medicare Clinical Laboratory Fee Schedule
MCM	Medicare Carrier's Manual
MCO	Managed Care Organization
MD	Medical Doctor
MDCN	Medicare Data Communication Network
MDE	Michigan Department of Education
MDHHS	Michigan Department of Health and Human Services (formerly Michigan Department of Community Health [MDCH] and Michigan Department of Human Services [DHS])
MDM	medical decision making
MDS	Minimum Data Set
MDS-HC	Minimum Data Set for Home Care
MEI	Medicare Economic Index
MER	Medicaid Eligibility Rate
MERF	Medical Eligibility Report Form
MHC	Mental Health Code
MHNP	Mental Health Nurse Practitioner
MHP	Medicaid Health Plan
MI	Mental Illness
MI Choice	Home and Community Based Waiver for the Elderly and Disabled
MI Enrolls	Michigan Enrolls

Acronym	Meaning
MICAS	Michigan Intensive Child and Adolescent Services
MichiCANS	Michigan Child and Adolescent Needs and Strengths
MICIS	MI Choice Information System
MiDPP	Michigan Diabetes Prevention Program
MIHP	Maternal Infant Health Program
MiLEAP	Michigan Lifelong Education, Advancement, and Potential
MIP	Medicaid Interim Payment
MI-VRP	Michigan Vaccine Replacement Program
	(text deleted 4/1/2025)
MMAP	Michigan Medicare/Medicaid Assistance Program
MMF	Michigan Medicaid Forms
MMHC	Michigan Mental Health Code
MMIS	Medicaid Management Information System
MNT	Medical Nutrition Therapy
MOA	Memorandum of Agreement
MOAHR	Michigan Office of Administrative Hearings and Rules
MOMS	Maternity Outpatient Medical Services
MOU	Memorandum of Understanding
MOUD	Medications for Opioid Use Disorder **(added 4/1/2025)**
MPH	Masters of Public Health
MPHI	Michigan Public Health Institute
MPPL	Michigan Pharmaceutical Product List
MPR	market penetration rate
MRADL	Mobility Related Activities of Daily Living
MRS	Michigan Rehabilitation Services
MSA	Metropolitan Statistical Area
MSBE	Michigan State Board of Education

Acronym	Meaning
MSD	Michigan School for the Deaf
MSHDA	Michigan State Housing Development Authority
MSP	Medicare Savings Program
MSW	Master of Social Work
MT-BC	Music Therapist - Board Certified
MTF	Military Treatment Facility
MTU	Miscellaneous Transaction Unit
MUE	Medically Unlikely Edit
NAC	National Autism Center
NADAC	National Average Drug Acquisition Cost
NCC	National Certified Counselor
NCCA	National Commission for Certifying Agencies
NCCI	Medicaid National Correct Coding Initiative
NCD	National Coverage Determination
NCHS	National Center for Health Statistics
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCT	National Clinical Trial
NCTRC	National Council for Therapeutic Recreation Certification
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NFT	Nursing Facility Transition
NHC	Nursing Home Compare
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health
NIMRC	National Institute for Medical Respite Care

Acronym	Meaning
NIPT	noninvasive prenatal testing
NLR	National Level Repository
NMNET	Non-medical (non-emergency) transportation
NMTR	National Music Therapy Registry
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NPA	National PACE Association
NPE	Neuropsychological Evaluation
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPPES	National Plan and Provider Enumeration System
NPSP	Non-Public Service Plan
NRC	Nuclear Regulatory Commission
NREPP	National Registry of Evidence-based Programs and Practices
NRRTS	National Registry of Rehabilitation Technology Suppliers **(added per bulletin MMP 24-58)**
NTA	Non-therapy ancillary-
NUBC	National Uniform Billing Committee
O & M	Orientation and mobility
OASIS	Outcome and Assessment Information Set
OB Profile	Routine prenatal laboratory services
OBAT	Office Based Alcohol Treatment
OBOT	Office Based Opioid Treatment
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OBSUT	Office-Based Substance Use Treatment
OCD	obsessive-compulsive disorder **(added 4/1/2025)**
OCE	Outpatient Code Editor
OCR	Office of Civil Rights; Optical Character Reader

Acronym	Meaning
OFIR	Office of Financial and Insurance Regulation
OIG	Office of Inspector General
OMA	Office of Medical Affairs
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
OPH	Outpatient Hospital
OPPC	Other Provider Preventable Condition
OPPS	Outpatient Prospective Payment System
OR	Operating Room
ORR	Office of Recipient Rights
OSA	Obstructive Sleep Apnea
OT	Occupational Therapy; Occupational Therapist
OTA	Occupational Therapy Assistant
OTC	Over the Counter
OTIS	Offender Tracking and Information System
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
P&O	Prosthetics and Orthotics
P&T	Pharmacy & Therapeutics
P/T	Part Time
PA	Prior Authorization; Physician's Assistant; Public Act
PACE	Program of All-Inclusive Care for the Elderly
PACER	Prior Authorization Certification Evaluation Review
PAHP	Prepaid Ambulatory Health Plan
PAMA	Protecting Accessing to Medicare Act of 2014
PAS	Pre-admission Screening
PASARR	Pre-admission Screening/Annual Resident Review

Acronym	Meaning
PBM	Pharmacy Benefits Manager
PBRHC	Provider Based Rural Health Clinic
PC	Professional Component
PC Pool	Primary Care Pool
PCP	Primary Care Physician; Person-Centered Planning; Primary Care Provider
PCS	Personal care services
PCSP	person-centered service plan
PCTP	person-centered transition plan
PDAC	Pricing, Data Analysis, and Coding
PD-CMP	per day Civil Money Penalty **(added 4/1/2025)**
PDD-NOS	Pervasive Developmental Disorder - Not Otherwise Specified
PDL	Preferred Drug List
PDN	Private Duty Nursing
PDPM	Patient Driven Payment Model
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PECOS	Provider Enrollment, Chain and Ownership System
PEDS	Parent's Evaluation of Developmental Status
PEME	Pre-Eligibility Medical Expenses
PERS	Personal Emergency Response System
PET	Program Enrollment Type
PHI	Protected Health Information
PHQ-9	Patient Health Questionnaire-9
PHQ-A	Patient Health Questionnaire-9 modified for Adolescents
PHS	Public Health Service
PI-CMP	per instance Civil Money Penalty **(added 4/1/2025)**
PIHP	Prepaid Inpatient Health Plan
PII	personally identifiable information **(added per bulletin MMP 24-61)**

Acronym	Meaning
PMR	Physical Medicine and Rehabilitation
PNP	Pediatric Nurse Practitioner
POA	Present on Admission
POC	Plan of Care; Plan of Correction
POL	Physician's Office Laboratory
POS	Point of Service; Plan of Service; Place of Service
PPA	Patient Pay Amount
PPACA	Patient Protection and Affordable Care Act
PPB	potential PACE beneficiaries
PPC	Provider Preventable Condition
PPI	Proton Pump Inhibitor
PPMP	Physician Performed Microscopy Procedures
PPO	Preferred Provider Organizations
PPR	Prospective Payment Rate
PPS	Prospective Payment System
PPS-1	Prospective Payment System 1
PR	Pulmonary Rehabilitation
PRC	peer recovery coach
PRD	Program Review Division
ProDUR	Prospective Drug Utilization Review
PSA	Prostate specific antigen
PSC	Pediatric Symptom Checklist
PSS	peer support specialist
PSV	paper service verification
PSYPACT	Psychology Interjurisdictional Compact
PT	Physical Therapy; Physical Therapist
PTA	Physical Therapy Assistant

Acronym	Meaning
PTAN	Provider Transaction Access Number
PTCA	Percutaneous Transluminal Coronary Angioplasty
PXRS	Portable X-ray Suppliers
Q/U/RM	Quality, Utilization and Risk Management
QAAF	Quality Assurance Assessment Factor
QAAP	Quality Assurance Assessment Program
QAS	Quality Assurance Supplement
QBHP	Qualified Behavioral Health Professionals
QBP	Quality Bonus Payment
QDWI	Qualified Disabled Working Individual
QHP	qualified health professional
QIDP	Qualified Intellectual Disabilities Professional [previously known as Qualified Mental Retardation Professional (QMRP)]
QMB	Qualified Medicare Beneficiary
QMHP	Qualified Mental Health Professional
QMI	Quality Measure Initiative
QRTP	Qualified Residential Treatment Program
RA	Remittance Advice
RAI	Resident Assessment Instrument
RAP	Refugee Assistance Program
RARSS	Reimbursement and Rate Setting Section
RBRVS	Resource Based Relative Value Scale
RBT	Registered Behavior Technician
RC	Recuperative Care
RCO	Recovery Community Organization
RD	Registered Dietitian
RDA	Recommended Dietary Allowance
RDH	Registered Dental Hygienist

Acronym	Meaning
RDRP	Rapid Dispute Resolution Process
REED	Re-evaluation of Existing Data
RESNA	Rehabilitation Engineering and Assistive Technology Society of North America **(added per bulletin MMP 24-58)**
RetroDUR	Retrospective Drug Utilization Review
RF	Reduction Factor
RFP	Request for Proposal
RHC	Rural Health Clinic
RMTS	Random Moment Time Study
RN	Registered Nurse
RNR	Registered Nurse Reviewer
RPM	remote patient monitoring
RSV	Respiratory Syncytial Virus
RVU	Relative Value Units
rWGS	rapid whole genome sequencing
SADMERC	Statistical Analysis DME Regional Carrier
SARF	Screening, Assessment, Referral, and Follow-up
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, & Referral to Treatment
SBS	School Based Services
SC	supports coordination
SCA	sudden cardiac arrest
SCD	sudden cardiac death
SCI	Spinal Cord Injury
SCQ	Social Communication Questionnaire
SDF	Silver Diamine Fluoride
SDOH	Social Determinants of Health
SE	Supported Employment

Acronym	Meaning
SED	Serious Emotional Disturbance
SEDW	Children with Serious Emotional Disturbances Home and Community Based Services Waiver
SFF	Special Focus Facility
SGA	Substantial Gainful Activity
SGD	Speech Generating Device
SHS	Short Hospital Stay
SI	Severity of Illness; Status Indicator
SI/IS	Severity of Illness and Intensity of Service
SIDS	Sudden Infant Death Syndrome
SIGMA VSS	State of Michigan Statewide Integrated Governmental Management Application Vendor Self Service system
SIS	Supports Intensity Scale
SIS-A	Supports Intensity Scale – Adult Version
SIS-C	Supports Intensity Scale – Children's Version
SLMB	Specified Low Income Medicare Beneficiary
SLP	Speech-Language Pathologist
SMA	State Medicaid Agency
SMDL	State Medicaid Director Letter
SMP	State Medical Plan
SNAP	Supplemental Nutrition Assistance Program
SNF	Skilled Nursing Facility
SNNU	Special Newborn Nursery Unit
SOC	Service Organization Control
SOM	State Operations Manual
SQC	Substandard Quality of Care
SRS-II	Social Responsiveness Scale-II
SS	Social Security

Acronym	Meaning
SSA	Social Security Administration; State Survey Agency
SSG	Service Selection Guidelines
SSI	Supplemental Security Income
SSN	Social Security Number
SSP	School Services Program
ST	Speech-Language Therapy
STD	Sexually Transmitted Disease
SUBC	State Uniform Billing Committee
SUD	substance use disorder
SUDHH	Substance Use Disorder Health Home
SVDCU	Sub-acute Ventilator-Dependent Care Unit
TABS	Temperament and Atypical Behavior Score
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Technical Component
TCM	Targeted Case Management
TCN	Transaction Control Number
TE	Transitional Employment
TEFRA	Tax Equality and Fiscal Responsibility Act of 1982
TENS	Transcutaneous Electrical Nerve Stimulator
TEP	Temporary Eligibility Period
THC	Tribal Health Center
TIG	Telephone Intake Guidelines
TIN	Tax Identification Number
TIP	Temporarily Ineligible Participant
TJC	The Joint Commission

Acronym	Meaning
TLSO	Thoracic-Lumbar-Sacral Orthosis
TMA	Transitional Medical Assistance
TMJ	temporomandibular joint
TN	transition navigator
TOB	Type of Bill
TPA	Therapeutic Pharmaceutical Agent
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
TPPB	true potential PACE beneficiaries
TTN	Transient Tachypnea of the Newborn
TTP	Thrombotic Thrombocytopenic Purpura
U&C	Usual and Customary
UMICAD	Upper Midwest Indian Council on Addiction Disorders
UPL	Upper Payment Limit
USC	United States Code
USPHS	U.S. Public Health Service
USPS	United States Postal Service
USPSTF	United States Preventive Services Task Force
USTF	Uniform Service Treatment Facility
VABS-2	Vineland Adaptive Behavior Scales - Second Edition
VB-MAPP	Verbal Behavior-Milestones Assessment and Placement Program
VBP	Value Based Purchasing
VFC	Vaccine for Children
VPI	Virginia Polytechnic Institute
W-2	IRS Form W-2 Wage and Tax Statement
WAC	Wholesale Acquisition Cost
WBC	White Blood Cell

Acronym	Meaning
WIC	Women, Infants and Children Program
WISC-IV	Wechsler Intelligence Scale for Children-IV
WISC-V	Wechsler Intelligence Scale for Children-V
WPATH	World Professional Association for Transgender Health
WPPSI-III	Wechsler Preschool and Primary Scale of Intelligence-III
WPPSI-IV	Wechsler Preschool and Primary Scale of Intelligence-IV
WSA	Waiver Support Application
YTD	Year-to-Date

DIRECTORY APPENDIX

This directory provides contact information referenced in the various chapters of the Medicaid Provider Manual, and is divided into the following topic areas:

Provider Assistance
Beneficiary Assistance
Eligibility Verification
Prior Authorization
Billing Resources
Claim Submission/Payment
Electronic Visit Verification
Policy/Forms/Publications
Appeals
Health Plan Information
Healthy Michigan Plan
Provider Resources
Behavioral Health/SUD Resources
Brain Injury Services
Community Health Worker Services
Community Transition Services
Doula Services Resources
Home Help
Hospice Resources
Maternal-Child Educational Resources
Maternal Infant Health Program Resources
MI Choice Waiver Resources
MI Health Link
Non-Emergency Medical Transportation
Nursing Facility Level of Care Determination
Nursing Facility Resources
Pharmacy Resources
Plan First Family Planning
Private Duty Nursing Resources
School Services Program
Telemedicine
Vision Services Resources
Reporting Fraud, Abuse, or Misuse of Services
Other Health Care Resources/Programs
Miscellaneous Contact Information

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER ASSISTANCE			
Provider Inquiry M-F 8 am to 5 pm EST	800-292-2550	MDHHS /Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider resource for billing assistance, including out-of-state and non-enrolled provider claims.
Atypical Providers M-F 8 am to 5 pm EST	800-979-4662	MDHHS/Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider and client resource for Home Help/Adult Foster Care/Non-Emergency Transportation services that involve questions of approved authorizations and payment information, along with submission of claims for personal care services.
CHAMPS Provider Enrollment On-Line System	1-800-292-2550	providersupport@michigan.gov	On-line provider enrollment application and information, on-line update of provider information, billing agent authorizations, etc.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Provider Enrollment Unit	1-800-292-2550 Fax 517-241-8233	MDHHS /Medicaid Payments Division Provider Enrollment Unit PO Box 30238 Lansing, MI 48909 email address: providerenrollment@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment	Change provider Pay To address. Use the CHAMPS PE contact information for all questions related to the enrollment process.
CHAMPS	Helpline: 1-800-292-2550	www.michigan.gov/medicaidproviders >> CHAMPS	Resources for information; training.
Children's Special Health Care Services (CSHCS)	517-241-7186 Fax 517-241-8970	CSHCS Program 400 S. Pine St., 4th floor Lansing, MI 48913 www.michigan.gov/cshcs	General information regarding CSHCS program.
CSHCS Customer Support	517-335-8986 Fax 517-335-9491 (submission of medical reports, applications, and all other information)	CSHCS Customer Support PO Box 30734 Lansing, MI 48909	Information about medical eligibility determinations, application process, coverage, requests for retroactive coverage, hospice, respite, or submission of client information updates.
MDHHS Diabetes and Other Chronic Diseases Section/Diabetes and Kidney Unit (DKU) – 1) Diabetes Self-Management Education Certification Program – Annual Statistical Data Report; 2) Michigan Diabetes Prevention Program	517-335-8853	MDHHS Chronic Disease and Injury Control Elliott-Larsen Building 5-N 320 S. Walnut St. Lansing, MI 48933 www.michigan.gov/diabetes >> Diabetes Self-Management Education Certification Program www.michigan.gov/diabetes >> Michigan DPP Medicaid benefit	1) Information about DSME certification, including the Annual Statistical Data Report; 2) Information about enrollment as a MiDPP provider.
MI Care Team		email address: MDHHS-MICareTeam@michigan.gov website: www.michigan.gov/micareteam	General information. Provider Resources, including: • MI Care Team Handbook • MSA-1030 • MDHHS-5515 • sample of Beneficiary Enrollment letter Consumer Resources • MI Care team sites • Map of participating counties
		email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
		email address: automatedbilling@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment >> Step-by-Step CHAMPS Enrollment Guides >> Billing Agent >> CHAMPS Enrollment Application Billing Agent User Guide.	Billing agent information.
		email address: MDHHSEncounterData@michigan.gov	Questions related to encounter file submission and FTS issues for MI Care Team organizations.
		website: www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual	Information and instructions relating to submitting data electronically and the File Transfer Service (FTS).
Peer Recovery Information		www.michigan.gov/MDHHS >> Keeping Michigan Healthy >> Adult Behavioral Health & Developmental Disability >> BH Recovery & Substance Use >> Peer Recovery Information	Resource information regarding the MDHHS peer support specialist and peer recovery coach training application and approval process.
Targeted Case Management Services for Recently Incarcerated Beneficiaries		Email address: providersupport@michigan.gov website: www.michigan.gov/medicaidproviders >> Targeted Case Management for Justice Involved Individuals	Provider Support contact information and additional provider resources, including FAQs, TCM Provider Attestation form, Policy Bulletin MMP 23-37, State Plan Amendment MI 22-0018.
BENEFICIARY ASSISTANCE			
Beneficiary Help Line M-F 8 am to 7 pm	800-642-3195	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979	Beneficiary resource for all programs administered by MDHHS, billing problems, **mihealth** card replacements, etc.
Beneficiary Pharmacy Help Line 24/7/365	877-681-7540	Prime Therapeutics State Government Solutions, LLC	Beneficiaries can receive answers to general pharmacy questions.
MI Enrolls (Michigan Enrolls) M-F 8 am to 7 pm	888-367-6557 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909	Health plan enrollment, provider participation information, and health plan change.
MIChild/MOMS	888-988-6300 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909 On-line application www.michigan.gov/mibridges	MIChild health plan enrollment, MIChild provider participation information, and MIChild health plan change.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Family Center for Children and Youth with Special Needs Family Phone Line M-F 8 am to 5 pm	800-359-3722 517-241-7630 fax 517-241-8970	CSHCS Family Center Capitol Commons Center, 4th floor 400 S. Pine St. Lansing, MI 48933 email: cshcsfc@michigan.gov	**For parent use only.** Information regarding CSHCS, Parent-to-Parent Support Network, camp and conference scholarships, sibling support, the Michigan Family Connections quarterly newsletter, other resource information, and transfer to state CSHCS staff and Local Health Department CSHCS offices.
Medicare Buy-In Unit	517-335-5488 Fax 517-335-0478	MDHHS /Buy-In Unit Elliott-Larsen Bldg. 320 S. Walnut St. Lansing, MI 48913 BuyInUnit@michigan.gov	Reviews Medicare/Medicaid dual eligible beneficiary information to determine if they qualify for the Medicare Buy-In/Medicare Savings Program.
ELIGIBILITY VERIFICATION			
CHAMPS Eligibility Inquiry	MDHHS Provider Inquiry Helpline 1-800-292-2550 for questions/ issues related to the eligibility response.	email: providersupport@michigan.gov Website: Log into CHAMPS using MILogin at https://milogintp.michigan.gov. Go to the Eligibility Inquiry hyperlink located on the 'Provider Portal' page under the 'Member' section. Benefit Plan Information: www.michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs. Refer to the Benefit Plan ID table in the Beneficiary Eligibility Chapter for a complete list of Benefit Plan IDs that are provided in the eligibility response. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.
CHAMPS 270/271 Batch Transaction		email: AutomatedBilling@michigan.gov Web Address: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Electronic Billing >> HIPAA - Companion Guides	A HIPAA 270/271 Batch option is available in CHAMPS for providers and/or their contracted clearinghouse vendors to verify eligibility. Refer to the HIPAA 5010 270/271 Inquiry Response Companion Guide for more information and/or the Electronic Submission Manual for upload availability.
Newborn ID Numbers	Fax 517-373-1437	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979 MSA-ESS@michigan.gov	Fax or e-mail requests to obtain newborn ID numbers for billing Medicaid only when an eligibility inquiry does not locate the newborn. Eligibility information must be obtained using the CHAMPS Eligibility Inquiry with the ID number provided by MDHHS. When submitting a request, include newborn's name, gender, date of birth, mother's name, and mother's Medicaid ID number.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MOMS Eligibility	Fax 517-241-8556	Customer Services Division Attn: MOMS Program	ONLY if MOMS ID number is not available through the CHAMPS Eligibility Inquiry or **mihealth** card. Request must be on provider letterhead and include provider's phone number and contact person.
Eligibility Verification (out-of-state providers)	1-800-292-2550		For out-of-state providers without internet access to verify eligibility for Medicaid, CSHCS, MOMS, and MIChild programs within the last 12 months.
Michigan Public Health Institute (MPHI)		email: MedicaidEligibility@mphi.org Web Address: https://hpb.mihealth.org	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs at no cost. Eligibility response data provided from CHAMPS. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.
			MPHI offers: Web-based system called MI Health Plan Benefits. To obtain access, go to https://hpb.mihealth.org >> Enrollment Form HIPAA X12 270/271 Realtime/batch transaction. For information, Enrollment Form, and Companion Guide, go to www.mihealth.org >> HIPAA 270/271 Transactions for Michigan Medicaid • MSA-1038 status tool: Search by Member ID or Name/DOB to determine the status of a submitted MSA-1038. Database is updated on a daily basis.
Medicare DSH Audits - Eligibility Verification for Dates of Service Over 12 Months for Hospital Providers	Michigan Public Health Institute (MPHI): (877) 816-0737 CHAMPS = MDHHS Provider Inquiry: 800-292-2550	**MPHI**: Website: HIPAA X12 270/271 Realtime/Batch Transaction website = http://www.mihealth.org/#HIPAA >> HIPAA 270/271 Transactions for Michigan Medicaid email: MedicaidEligibility@mphi.org **CHAMPS**: Website: www.michigan.gov/tradingpartners >> HIPAA –Companion Guides Mailing Address: MDHHS /Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 email: providersupport@michigan.gov	The following options are available for hospital providers to verify eligibility for DOS over 12 months for Medicare DSH audits: • **MPHI** = 270/271 Realtime/Batch Transactions • **CHAMPS** = Member Eligibility Inquiry • **CHAMPS** = 270/271 Batch Transaction Hospital providers that contract with clearinghouse vendors to submit/receive their DSH inquiries must have the vendor listed as one of their approved billing agents on CHAMPS (PE subsystem).

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PRIOR AUTHORIZATION (Authorization of Services)			
Program Review Division, Benefits Monitoring Program	855-808-0312 fax 517-335-0075	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909-7979	Inquiries by beneficiaries and providers regarding the Benefits Monitoring Program.
Program Review Division (FFS Medicaid & CSHCS)	800-622-0276 fax 517-335-0075	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for all services except hospital, specified durable medical equipment, pharmacy, and non-emergency medical transportation.
Prior Authorization (MHP)	See Health Plan list on MDHHS website	Obtain specific health plan contact information at: www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	For beneficiaries enrolled in a health plan, providers are to contact the plan for authorization of services.
Prior Authorization - Dental (FFS Medicaid & CSHCS)	800-622-0276 fax 517-335-0075 Change Request fax number: 517-241-7813	MDHHS Dental Prior Authorization PO Box 30154 Lansing, MI 48909	Prior authorization of dental services for Medicaid and CSHCS.
Prior Authorization – Non-Emergency Medical Transportation (NEMT)	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for FFS Medicaid non-emergency medical transportation
Prior Authorization - Specified DME and Medical Supplies	844-PACERMI (844-722-3764)	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Telephone prior authorization of specified DME and medical supplies (applies to applicable procedure codes requiring telephone prior authorization in the Medical Supplier chapter of the MDHHS Medicaid Provider Manual).
Prior Authorization (PACER) – Med/Surg Inpatient Admissions	844-PACERMI (844-722-3764)	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for Medicaid and CSHCS admissions.
Prior Authorization (PACER) Acute Care Hospital to Long Term Acute Care Hospital (LTACH)	844-PACERMI (844-722-3764)	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for Medicaid, Healthy Michigan Plan, and CSHCS admissions.
Prior Authorization – Psychiatric Inpatient Admissions	Refer to local Community Mental Health Services Program		
Prior Authorization – Private Duty Nursing FFS Medicaid	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for FFS Medicaid PDN services.
Prior Authorization – Private Duty Nursing Children's Waiver & Habilitation Supports Waiver		Contact beneficiary's case manager/ supports coordinator at their local Community Mental Health Services Program (CMHSP)	Prior authorization for Children's Waiver and Habilitation Supports Waiver PDN services.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Prior Authorization – Ventilator-Dependent Care Units	844-PACERMI (844-722-3764)	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Authorization for Medicaid reimbursement in contracted ventilator dependent care units.
Prior Authorization – NF Complex Care	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Authorization for increased NF per diem for complex care.
Prior Authorization – Pharmacy (PBM Technical Call Center) 24/7/365	877-624-5204 fax 877-888-6370	Prime Therapeutics State Government Solutions, LLC 4300 Cox Rd. Glen Allen, VA 23060	Non-clinical prior authorization and early refills
Prior Authorization – Recuperative Care	844-RECUP-MI (844-732-8764)	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Telephonic prior authorization for Targeted Case Management - Recuperative Care
Pharmacy Clinical Call Center (PBM Clinical Call Center) 7 am – 7 pm EST, M – F After-hours calls rollover to the PBM Technical Call Center	877-864-9014 fax 887-888-6370 fax 800-250-6950	Prime Therapeutics State Government Solutions, LLC 4300 Cox Rd. Glen Allen, VA 23060	Prescribers call for prior authorization clinical reasons and non-preferred drug products. Pharmacies call for dollar amount limits and Medicare Part B coinsurance.
BILLING RESOURCES			
American Dental Association		https://www.ada.org/	Obtain ADA claim forms and ADA claim completion instructions. **(text added 7/1/2025)**
Automated Billing Unit/ Electronic Billing Resources	fax 517-335-3766	Automated Billing Unit PO Box 30731 Lansing, MI 48909 AutomatedBilling@michigan.gov	Information regarding becoming an electronic biller and submitting electronic claims to MDHHS. 835 & 837 Companion Guides, Testing Instructions, and MDHHS Electronic Submission Manual are available at www.michigan.gov/tradingpartners
Beneficiary Co-Payments		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment Requirements www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment FAQ Healthy Michigan Plan: www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Provider Information	Beneficiary co-payment requirements; frequently asked questions
CDT Coding Manual (American Dental Assoc.)	800-947-4746		Procedure codes required for dental claims.
Centers for Medicare & Medicaid Services (CMS)		www.cms.gov	Provider resource for CMS guidelines, HCPCS Codes, and National Physician Fee Schedule Relative Value Files.
CPT Coding Manual, HCPCS Coding Manual, ICD Coding Manual			Procedure and diagnosis coding required for professional and institutional claims. Available for purchase from a variety of vendors.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Procedure Code Databases/Fee Screens, Documentation Requirements, Readmission Example, etc.	517-284-1245	www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information	MDHHS-covered procedure codes, parameters, fee screens, 15-day readmission example, OPPS Wraparound Code Lists for each provider type available on-line, Revenue Code Requirement Table.
MDHHS Institutional Billing Resource		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information (>> "Inpatient Hospital" or "Outpatient")	Billing updates.
MDHHS Sanctioned Providers List		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> List of Sanctioned Providers U.S. Department of Health & Human Services (HHS) Sanctioned Providers: https://exclusions.oig.hhs.gov MDHHS Licensing Actions: www.michigan.gov/healthlicense and www.michigan.gov/bchs MDHHS Licensing Actions: www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Licensing	List of providers that are excluded from participation in Michigan Medicaid, CSHCS, etc.
Medicaid Code and Rate Reference Tool		Log into CHAMPS using MILogin at https://milogintp.michigan.gov. Go to the External Links menu located on the 'Provider Portal' page. Select 'Medicaid Code and Rate Reference' from the dropdown list.	Real-time information regarding MDHHS -covered procedure codes, parameters, and fee screens.
Medicare Crossover Claims		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Medicare Crossover	Information regarding Medicare Crossover billing and exclusions.
Medicaid National Correct Coding Initiative (NCCI)	fax 317-571-1745	Medicaid National Correct Coding Initiative Correct Coding Solutions, LLC PO Box 907 Carmel, IN 46082-0907 https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html	Information regarding Medicaid NCCI. Questions regarding NCCI coding policies and edits may be directed to the CMS NCCI Contractor: Correct Coding Solutions, LLC.
National Uniform Billing Committee (NUBC) Manual		American Hospital Association National Uniform Billing Committee PO Box 92247 Chicago, IL 60675-2247 www.nubc.org	To obtain a NUBC manual.
National Uniform Claim Committee		www.nucc.org	To obtain CMS-1500 (02-12) claim forms or NUCC standard claim completion instructions.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicare Pricing, Data Analysis, and Coding (PDAC); Contractor: Noridian Administrative Services, LLC	877-735-1326 (9:00 a.m.-4:00 p.m. EST)	http://www.dmepdac.com	Enteral Product Classification List; DME information.
Washington Publishing Co.		PMB 161 5284 Randolph Rd Rockville, MD 20852-2116 www.wpc-edi.com	Information regarding HIPAA compliant claim formats and code sets.
CLAIM SUBMISSION/PAYMENT			
Document Management Portal		www.michigan.gov/medicaidproviders >> Document Management Portal	Document Management Portal information and tutorials.
Vendor Registration and Electronic Funds Transfer		State Budget Office www.michigan.gov/SIGMAVSS	Register provider SSN or EIN/TIN, initiate receipt of electronic Medicaid payments.
Friend of the Court	517-373-5975 Fax 517-373-8740	Friend of the Court Bureau State Court Administrative Office Michigan Hall of Justice PO Box 30048 Lansing, MI 48909 FOCB@courts.mi.gov	Qualifying medical support orders.
MDHHS Cashier's Unit		MDHHS Cashier's Unit 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Refund payments to MDHHS, purchase Medicaid manual subscription.
		MDHHS - Cashier's Unit Attn.: Bureau of Finance - MCU 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Provider returning overpayments.
Paper Claim Submission		MDHHS PO Box 30043 Lansing, MI 48909	CMS-1500 (02-12), CMS-1450 (UB-04), and ADA **(text deleted 7/1/2025)** claims are to be mailed to the address indicated. No other paper claim formats are accepted.
Pharmacy Paper Claim Submission		Prime Therapeutics State Government Solutions, LLC Michigan Paper Claims Processing Unit PO Box C-85042 Richmond, VA 23261-5042	Address to submit paper pharmacy claims.
Sterilization & Hysterectomy Forms Submission	Fax 866-229-6675		Fax completed form according to Document Management Portal instructions. Form may be downloaded from the MDHHS website at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Third Party Liability Section	800-292-2550 (option #4) fax 517-346-9817	MDHHS /TPL PO Box 30479 Lansing, MI 48909-7979 TPL_Health@michigan.gov	Coordination of benefits issues.
ELECTRONIC VISIT VERIFICATION			
Home Health Billing and Reimbursement		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Home Health	
Live-in Caregiver Attestation Form		www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms	Form BPHASA-2421
Michigan EVV Vendor		Website: HHAeXchange website	
MILogin Registration		https://milogintp.michigan.gov	Register for a MILogin User ID and password
National Plan and Provider Enumeration System (NPPES)		https://nppes.cms.hhs.gov	Website to get National Provider Identifier (NPI) number
POLICY/FORMS/PUBLICATIONS			
Medicaid Policy Division		MDHHS /Medicaid Policy PO Box 30479 Lansing, MI 48909 MSAPolicy@michigan.gov	Policy questions, etc. Billing questions/problems and general policy questions should be directed to Provider Inquiry at 1-800-292-2550.
Draft Medicaid Policy	517-284-1245	MSADraftPolicy@michigan.gov	Proposed policies are distributed for a 30-day public comment period. Copies of proposed policies may be requested via e-mail or obtained from the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
ListServ Communications		www.michigan.gov/medicaidproviders >> Listserv Instructions (under Resources)	Subscription instructions.
Medicaid Forms Distribution		MDHHS Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 E-mail: MSA-Forms@michigan.gov	Many required forms are available in the Forms Appendix of this manual and on-line at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Medicaid Policy Manuals and Bulletins	517-284-1245	MSAPolicy@michigan.gov	Copies of policy bulletins. This information is also available on-line at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Michigan Medicaid Provider Manual (CD version)		MDHHS /Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 MSA-Forms@michigan.gov	Michigan Medicaid Provider Manual on compact disc (CD).
Medicaid Publications		MDHHS Health Promotions & Publications 320 S. Walnut Lansing, MI 48913 www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Medicaid brochures and other publications.
Numbered Letters		www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Copies of numbered letters.
U.S. Department of Health & Human Services (HHS)		http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs	Consent for Sterilization form (HHS-687)
APPEALS			
Appeals/Administrative Hearings (Beneficiary)	800-648-3397 or (517) 335-7519 Fax (517) 763-0146	Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services PO Box 30763 Lansing, MI 48909	For questions about sending in a hearing request or on the administrative hearings process, once a MDHHS action has been taken or adverse benefit determination has been appealed through the managed care entity.
Appeals/Administrative Hearings/Department Reviews (Beneficiary)	877-833-0870	MDHHS Appeals Section PO Box 30807 Lansing, MI 48909	For questions about a MDHHS action with rights for an administrative hearing or department review.
Appeals/Administrative Hearings (Provider)	800-648-3397 or 517-335-7519 Fax 517-763-0146	Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services PO Box 30763 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> (under 'Resources') Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services http://www.michigan.gov/lara >> Bureaus >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code: A compilation of all adopted rules and regulations that are in effect in the State of Michigan >> Select Department: Health and Human Services >> Bureau: Behavioral and Physical Health and Aging Services Administration >> MSA Provider Hearings	For questions about requesting an administrative hearing with Michigan Office of Administrative Hearings and Rules (MOAHR) or the hearings process for provider appeals.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
		http://www.michigan.gov/lara >> Bureaus >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC)	
Appeals/Administrative Hearings/Informal Conferences (Provider)	877-833-0870	MDHHS Appeals Section PO Box 30807 Lansing MI 48909 www.michigan.gov/medicaidproviders >> (under 'Resources') Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services	For questions about MDHHS actions with rights for informal conferences or administrative hearings with MOAHR.
		http://www.michigan.gov/lara >> Bureaus >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code: A compilation of all adopted rules and regulations that are in effect in the State of Michigan >> Select Department: Health and Human Services >> Behavioral and Physical Health and Aging Services Administration >> MSA Provider Hearings	
		http://www.michigan.gov/lara >> Bureaus >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC)	
State Hospital Appeals Panel Coordinator		State Hospital Appeals Panel Coordinator Michigan Office of Administrative Hearings and Rules PO Box 30763 Lansing, Michigan 48909	Hospitals wishing to waive right to appeal through the administrative rules, R400.3406 through R400.3424, may elect to request a hearing before the State Hospital Appeals Panel.
HEALTH PLAN INFORMATION			
Dental Health Plans		Web Address: www.michigan.gov/healthykidsdental	Information related to ***Healthy Kids Dental*** enrollees, services, claims, and Dental Health Plans.
Medicaid Health Plans	517-284-1162	www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	Information regarding Medicaid Health Plans.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicaid Health Plan Carveout		Medicaid Health Plan Pharmacy Program Carve-out https://mi.primetherapeutics.com >> Provider >> Documents >> Carveout Coverage >> Medicaid Health Plan Carveout Medicaid Health Plan Injectable Drugs and Biologicals Carve-out www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	Drugs in the categories listed on the MHP carveout list are excluded from the MHP contract.
Pre-paid Inpatient Health Plan Contract Managers	517-241-5066	www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Information regarding Mental Health and Substance Use Disorder treatment services available through the Pre-paid Inpatient Health Plans.
Delta Dental Customer & Claims Services Department	800-482-8915		Information related to ***Healthy Kids Dental*** enrollees, services, and claims.
PIHP Contact Information, Service Areas		www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Contact information for Mental Health & Substance Abuse.
HEALTHY MICHIGAN PLAN			
Preventive and Wellness Services		United States Preventive Services Task Force grade A and B services http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Advisory Committee on Immunization Practices recommended vaccines http://www.cdc.gov/vaccines/hcp/acip-recs/index.html Institute of Medicine recommended preventive services for women http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx Current periodicity schedule by the American Academy of Pediatrics http://brightfutures.aap.org/clinical_practice.html	Resources for covered preventive and wellness services.
Healthy Michigan Plan Provider Webpage		www.michigan.gov/healthymichiganplan	Healthy Michigan Plan information and resources for providers.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER RESOURCES			
MDHHS Bureau of Epidemiology and Population Health; Division of Communicable Diseases	517-335-8165 517-335-9030 (After Hours) Fax 517-335-8263	MDHHS Bureau of Epidemiology and Population Health Division of Communicable Diseases 333 S. Grand Ave., 3rd Floor Lansing, MI 48913 www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Communicable & Chronic Diseases >> Communicable Disease Information and Resources	Disease reporting, commonly used forms, press releases and other useful information.
MDHHS Bureau of Family Health Services; Division of Immunization	517-335-8159 517-335-9030 (After Hours)	MDHHS Bureau of Family Health Services Division of Immunization 333 S. Grand Ave., 3rd Floor Lansing, MI 48913 www.michigan.gov/mdhhs >> Adult & Children's Services >> Children & Families >> Immunization Info for Families & Providers	Immunization schedules, commonly used forms, press releases and other useful information.
MDHHS Bureau of Laboratories – Data and Specimen Handling (DASH) Unit	517-335-8059 Fax 517-335-9871	MDHHS Bureau of Laboratories – Trace Metals Section 3350 N. Martin Luther King Jr. Blvd. PO Box 30035 Lansing, MI 48909 www.michigan.gov/mdhhslab www.michigan.gov/documents/DCH-0696_157219_7.pdf	Obtain clinic code; Download Blood Lead Test Request form (DHHS-0696).
MDHHS Bureau of Laboratories, Trace Metals Section	517-335-8244	Website: www.michigan.gov/mdhhslab	Lead testing (technical questions).
MDHHS Bureau of Laboratories – Warehouse	517-335-9040 Fax 517-335-9039	email: mdhhslab@michigan.gov	Order testing supplies.
MDHHS Childhood Lead Poisoning Prevention Program	517-335-8885 Fax 517-335-8509	MDHHS Childhood Lead Poisoning Prevention Program PO Box 30195 Lansing, MI 48909 Web address: www.michigan.gov/lead	Education and outreach related to blood lead poisoning.
MDHHS Diabetes and Other Chronic Diseases Section/Diabetes and Kidney Unit; Diabetes Self-Management Education Certification Program – Annual Statistical Data Report	517-373-2818 Fax 517-335-9461	MDHHS Diabetes and Kidney Unit WSB – 7th Floor PO Box 30195 Lansing, MI 48909-0001 www.michigan.gov/diabetes >> Diabetes Self-Management Education Certification Program	Information about DSME certification, including the Annual Statistical Data Report.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Diaper & Incontinence Supply Contract	800-737-0045 Fax 800-737-0012 Fax for hospital prescriptions: 800-737-0012 TTY: 800-737-0084	J & B Medical 4305 Pineview Dr., Ste. 100 Commerce Township, MI 48390	Volume purchase contract for select incontinence supplies. Refer to the Medical Supplier Chapter for additional information.
MDHHS Early Hearing Detection and Intervention (EHDI) Program)	Fax 517-335-8036	www.michigan.gov/mdhhs >> Adult & Children's Services >> Children & Families >> Early Hearing Detection and Intervention >> The Birth Hospital's Role in Newborn Hearing Screening >> Audiological/Medical Follow-Up Services Report DCH-0120	Report results of all hearing tests and screenings; Audiological/Medical Follow-Up Services Report form (DCH-0120).
MDHHS – File Transfer	Client Service Center: 1-800-968-2644	Log into MDHHS – File Transfer using MILogin: https://milogintp.michigan.gov Assistance with MILogin can be found online at www.michigan.gov/mdhhs-milogin-info	
MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section	517-241-8764	MDHHS Bureau of Purchasing Grants Division Electronic Grants Section 235 S. Grand Ave., Ste. 1201 Lansing, MI 48913	Local Health Department Agreements.
MDHHS Healthy Homes Section	517-335-9390 Fax 517-335-8800	MDHHS Healthy Homes Section PO Box 30195 Lansing, MI 48909 Web address: www.michigan.gov/leadsafe	Obtain Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials.
MDHHS Hospital 15-Day Readmission Guidelines		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Readmission guidelines for hospitals and Medicaid Health Plans.
MDHHS Infant Oral Health Training	517-335-8879 Fax 517-346-9862	Education/Fluoride Coordinator Oral Health Program Michigan Department of Health and Human Services PO Box 30195 Lansing, MI 48909 oralhealth@michigan.gov www.michigan.gov/oralhealth www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Dental	Assistance for medical providers on training programs and other resource materials. Provides certification for, and monitoring of, medical providers on infant oral health.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Injury and Violence Prevention Section	517-335-9518 Fax 517-335-9669	MDHHS Injury and Violence Prevention Section PO Box 30195 Lansing, MI 48909 www.michigan.gov/mdhhs >> Safety & Injury Prevention >> Injury & Violence Prevention	Public health prevention resources to reduce morbidity, mortality, and risk behaviors related to unintentional and intentional injuries.
MDHHS Mobile Dentistry		www.michigan.gov/oralhealth >> Mobile Dentistry	Mobile Dental Facility Application
MDHHS Newborn Screening Section	517-335-8095	MDHHS Bureau of Laboratories Newborn Screening Section 3350 N. Martin Luther King Jr. Blvd. Lansing, MI 48906 www.michigan.gov/mdhhs >> Adult & Children's Services >> Hereditary Disorders	Blood samples and each newborn's pulse oximetry screening results are to be reported to the MDHHS Newborn Screening Section. Complete list of newborn blood screening disorders.
Recovery Audit Contractor	614-801-0495	CoventBridge 2118 Southwest Blvd. Grove City, OH 43123 https://www.michigan.gov/mdhhs/inside-mdhhs/office-of-inspector-general	Audit resources for providers.
MDHHS Oral Health Program		Email: OralHealth@michigan.gov Web Address: www.michigan.gov/oralhealth	Education and technical assistance on oral health resources regarding oral screenings, caries risk assessment, and fluoride varnish applications.
Advisory Committee on Immunization Practices (ACIP)		www.cdc.gov/vaccines/acip	Information regarding immunization and vaccine recommendations and standards of practice.
American Academy of Pediatric Dentistry (AAPD)		https://www.aapd.org/research/oral-health-policies--recommendations/	Guidelines on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment.
		http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf	Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling.
		http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf	Caries Risk Assessment Tool
American Academy of Pediatrics (AAP)		www.aap.org >> About the AAP >> Committees, Councils & Sections >> Section Websites >> Oral Health >> Resources	Oral health resources.
		http://www.aap.org >> Professional Resources >> Clinical Support >> Connected Kids >> Materials >> Connected Kids Clinical Guide	Connected Kids: Safe, Strong, Secure clinical guide on youth violence and injury prevention.
		http://brightfutures.aap.org >> Materials >> Practice Guides and Other Resources	Practice guides on oral health, mental health, and physical activity.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
		http://www.aap.org >> Professional Resources >> Red Book Resources	Tuberculosis information regarding risk and testing.
American Medical Association (AMA)		https://www.validatebp.org/	U.S. Blood Pressure Validated Device Listing of blood pressure monitors that meet the AMA's criteria for clinical accuracy.
Centers for Disease Control and Prevention (CDC)	800-CDC-INFO (800-232-4636)	Website: https://www.cdc.gov/nceh/lead	Lead exposure/poisoning prevention resources.
Clinical Laboratory Improvement Amendments (CLIA)		https://www.cms.gov/Regulations-and-guidance/Legislation/CLIA/Downloads/waivetbl.pdf	List of CLIA-waived lab tests.
Community Health Centers/Federally Qualified Health Centers		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Help Finding Health Care >> Free or Low Cost Primary Care from a Doctor or Nurse	Source for Free or Low Cost Primary Care.
Consent to Share Behavioral Health Information form (MDHHS-5515)		email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.
Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit		www.gladpc.org >> GLAD-PC Toolkit	Information, recommendations, educational resources, and tools to aid in the management of adolescent depression in primary care.
Hospital Attending Provider Types Lists		Website: https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/medicaid-provider-alerts/data/pages/institutional	
Medicaid Health Plan Carve-out		www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	A list of outpatient physician-administered drugs and biological products carved-out from the Michigan Medicaid Health Plans (MHPs).
Medicaid State Plan		Web Address: www.michigan.gov/medicaid >> Program Resources	
Mental Health Screening and Assessment Tools for Primary Care		www.aap.org >> Advocacy & Policy >> AAP Health Initiatives >> Clinical Resources >> Mental Health >> Key Resources >> Primary Care Tools >> Mental Health Screening and Assessment Tools for Primary Care	Listing of mental health screening and assessment tools.
Michigan Automated Prescription System (MAPS)		www.michigan.gov/mimapsinfo	Michigan's prescription drug monitoring program. MAPS is used to identify and prevent drug diversion at the prescriber, pharmacy, and patient level.

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Michigan Care Improvement Registry (MCIR)		http://www.mcir.org	All immunizations must be reported to the MCIR.
Michigan's Great Start Trauma Informed System		www.michigan.gov/traumatoxicstress	To add a trauma informed approach into the comprehensive early childhood system known as Great Start.
Michigan Poison and Drug Information Center (MiPDC)	800-222-1222	Website: https://www.poison.med.wayne.edu	Lead exposure/poisoning prevention resources.
National Institute for Medical Respite Care		https://nimrc.org/standards-for-medical-respite-programs/	Information for Targeted Case Management - Recuperative Care: the National Institute for Medical Respite Care (NIMRC) standards for medical respite care.
National Lead Information Center	800-424-LEAD (5323)	Website: https://www.epa.gov/lead	Lead exposure/poisoning prevention resources.
OASIS		www.cms.hhs.gov/OASIS	Mandated assessment for Home Health services.
OASIS HelpDesk	888-324-2647 or 517-241-2628		Assistance in transmitting OASIS data to the state repository.
Office of Medical Affairs	517-335-5181	MDHHS /Office of Medical Affairs PO Box 30479 Lansing MI 48909	
Pediatric Environmental Health Specialty Unit (PEHSU)	866-967-7337	Email: pehsu@aap.org	Lead exposure/poisoning prevention resources.
Reimbursement & Audit	517-335-5330	MDHHS /Hospital and Clinic Reimbursement Division PO Box 30479 Lansing, MI 48909-7979 www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Information on hospital and health plan rates and audits.
Smiles for Life		www.smilesforlifeoralhealth.org	Comprehensive oral health curriculum designed to enhance the role of primary care clinicians in promoting oral health. Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module at www.smilesforlifeoralhealth.org and obtain certification prior to providing oral health screenings and fluoride varnish applications.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
State Survey Agency (Non-Long Term Care Facilities)	517-335-1980 fax 517-241-3354	Department of Licensing and Regulatory Affairs Bureau of Survey and Certification 611 W. Ottawa St. PO Box 30838 Lansing, MI 48909 www.michigan.gov/bsc	Hospital, ESRD, OPT/CORF, RHC, Hospice, Home Health Agencies, Clinical Labs, FSOF/ASC, Psychiatric hospitals
United States Preventive Services Task Force (USPSTF)		www.uspreventiveservicestaskforce.org	Information regarding preventive service recommendations.
Women, Infants, and Children (WIC) Program	800-262-4784	https://www.michigan.gov/wic	Michigan WIC Client Portal site connects beneficiaries with a local WIC agency and provides additional resources regarding supplemental healthy foods, nutrition counseling and education, breastfeeding support, immunization screening, and referrals to other helpful services to pregnant, breastfeeding, and post-partum women, infants, and children younger than five years of age.
BEHAVIORAL HEALTH/SUD RESOURCES			
Medicaid Code Chart/Modifiers		Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	Behavioral Health Code Charts and Provider Qualifications document.
Behavioral Health Home		Email address: MDHHS-BHDDAHealthHomes@michigan.gov Website: www.michigan.gov/bhh	General information. Consumer Resources: Behavioral Health Home Directory; Behavioral Health Home Brochure. Provider Resources: Behavioral Health Home Handbook; Policy Bulletins MSA 20-48, HASA 22-09, MMP 23-16, and MMP 24-24; State Plan Amendment Approval Letter; Health Home Provider Application; Behavioral Health Home Brochure and Poster; Behavioral Health Home Directory; Behavioral Health Home Encounter Codes and Rates; Care Plan Example.
		Email address: MDHHS-BHconsent@michigan.gov Website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.
		Email address: MDHHSEncounterData@michigan.gov	Questions related to encounter file submission and FTS issues.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Certified Community Behavioral Health Clinic Demonstration		Email address: MDHHS-CCBHC@michigan.gov Website: www.michigan.gov/ccbhc	General information. Consumer resources: • CCBHC Directory Provider resources: • CCBHC Demonstration Handbook • MMP 23-56 • CCBHC Directory
		Email address: MDHHS-BHconsent@michigan.gov Website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.
		Email address: MDHHSEncounterData@michigan.gov	Questions related to encounter file submission and ITS issues.
		Website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	PPS-1 Rate: Behavioral Health Code Charts and Provider Qualifications document
Children's Waiver Program	517-241-5757	MDHHS – BCCHPS Program and Grant Development and Quality Monitoring Division Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Submission of Prior Review and Approval Request (PRAR) form and documentation.
International Center for Clubhouse Development (ICCD)		http://www.iccd.org/certification.html	Information regarding Clubhouse International accreditation.
		http://www.iccd.org/images/employment_guidelines_2012.pdf	Clubhouse International standards and guidelines.
MDHHS-BPHASA Community Based Practices and Innovation Section, Division of Adult Home and Community Based Services	517-335-0499	MDHHS-BPHASA Community Based Practices and Innovation Section Division of Adult Home and Community Based Services Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Requests for approval of Clubhouse services.
National Registry of Evidence-based Programs and Practices (NREPP)		www.samhsa.gov/nrepp	Clubhouse model.
Network Adequacy Standards		website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html	Policy and procedural document.
PIHP Provider Registry	517-373-2568	MDHHS - BPHASA Division of Contracts and Quality Management Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Information regarding how to register a new service provider, delete a service provider. or change information about the service provider.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PIHP Special Program Approval	517-335-0499	MDHHS - BPHASA Community Based Practices and Innovation Section Division of Adult Home and Community Based Services Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Information regarding how to obtain approval of new special programs: ACT, PSR, crisis residential, and intensive crisis stabilization.
Substance Use Disorder Health Home		Email address: MDHHS-BHDDAHealthHomes@michigan.gov Website: www.michigan.gov/sudhh	General information. Consumer Resources: Substance Use Disorder Health Home Directory; Substance Use Disorder Health Home Brochure and Poster. Provider Resources: State Plan Amendment Approval Letter; Substance Use Disorder Health Home Handbook; Policy Bulletins; Health Home Provider Application; Substance Use Disorder Health Home Directory; Substance Use Disorder Health Home Brochure and Poster; Substance Use Disorder Health Home Encounter Codes and Rates.
		Email address: MDHHS-BHconsent@michigan.gov Website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.
		Email address: MDHHSEncounterData@michigan.gov	Questions related to encounter file submission and FTS issues
BRAIN INJURY SERVICES			
Brain Injury Services	517-241-4100	Home and Community Based Services Section 400 S. Pine St. Lansing, MI 48913 E-mail: MSA-TBIWAIVER@michigan.gov	General Information.
COMMUNITY HEALTH WORKER SERVICES			
MI Medicaid CHW Registry		www.michwa.org/mi-medicaid-chw-credential-registry/	MI Medicaid CHW Registry information and application.
MDHHS CHW website		www.michigan.gov/medicaidproviders >> Community Health Workers	Information on the CHW policy, process and requirements for CHWs to deliver Medicaid reimbursable services.
MDHHS Medicaid Provider Enrollment website		www.michigan.gov/medicaidproviders> > Provider Enrollment	Step-by-step CHAMPS enrollment guides based on provider type.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Clinic Institutional Billing website		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Clinic Institutional Billing	Information on procedure code coverage by clinic type.
COMMUNITY TRANSITION SERVICES			
Community Transition Services	517-241-4100	Home and Community Based Services Section 400 S. Pine St. Lansing, MI 48913 E-mail: MDHHS-MSA-NFTSERVICES@michigan.gov https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-481963--,00.html	Webpage specific to Community Transition Services where program information is posted.
Critical Incident Reporting System	Phone: 517-241-8474 Fax: 517-241-7816	MDHHS Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://webapp.ciminc.com/CompassMI	Resource for gaining access to and using the Critical Incident Reporting System to enter critical incidents as required by policy.
DOULA SERVICES RESOURCES			
MDHHS Doula Initiative		Email: MDHHS-MIDoula@michigan.gov Website: https://www.michigan.gov/Doula	Information regarding the MDHHS Doula Registry and Doula Advisory Council. Resources for doula providers.
HOME HELP			
Adult Services Manual Table of Contents		https://dhhs.michigan.gov/OLMWeb/ex/AS/Public/ASM/000.pdf	Includes hyperlinks to all sections of the Adult Services Manual referenced in the Home Help chapter. To access an ASM, click on its Manual/Code number or Title.
Centralized Intake for Abuse and Neglect	855-444-3911		To make an oral report regarding suspected abuse, neglect or exploitation of adults.
General Home Help Provider Questions		Email: MDHHS-HHProviderQuestions@michigan.gov	General Home Help provider questions

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Home Help Webpage		www.michigan.gov/homehelp	Includes information about applying to become a Home Help provider, documenting and billing services, payment rates and schedules, CHAMPS enrollment, and receiving automatic updates on Home Help policies and procedures.
Local MDHHS Offices		www.michigan.gov/mdhhs >> Inside MDHHS >> County Offices	Contact information for MDHHS adult services staff.
New Agency Application	Fax: 517-241-0067	e-mail: MDHHS-HHNewAgencyProviderApplications@michigan.gov Michigan Department of Health and Human Services Home Help Policy Section P.O. Box 30479 Lansing, MI 48909	To submit an application to become an approved agency provider.
New Agency Provider Compliance Review and Agency Provider Audits	Fax: 517-241-0067	**Email Address:** MDHHS-HHAgencyAudits@michigan.gov Michigan Department of Health and Human Services Home Help Policy Section P.O. Box 30479 Lansing, MI 48909	To submit required documents for an audit.
Paper Service Verification (PSV)	Fax: 517-763-0111	MDHHS Adult Home Help P.O. Box 26007 Lansing, MI 48909	To submit a PSV for payment.
Request for Reinstatement as an Approved Agency Provider		**Email Address:** MDHHS-HHAgencyAudits@michigan.gov	To request reinstatement of approved agency provider status and payment rate.
Statewide Integrated Governmental Management Application Vendor Self Service system (SIGMA VSS)	Phone: 888-734-9749	**Email Address:** To receive assistance from the SIGMA Vendor Help Desk: SIGMA-Vendor@michigan.gov **Web Address:** To create a vendor account with the State of Michigan: www.michigan.gov/vsslogin **Web Address:** To manage payment information and view financial transactions: www.Michigan.gov/SIGMAVSS	SIGMA VSS is the payment portal for agency providers.
Voluntary Provider Disenrollment		**Email Address:** MDHHS-HHAgencyAudits@michigan.gov and providerenrollment@michigan.gov	To disenroll as a Home Help provider.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
HOSPICE RESOURCES			
MDHHS Hospice Enrollment Coordinator	517-335-5567		Contact only if hospice services began prior to a health plan enrollment.
MATERNAL-CHILD EDUCATIONAL RESOURCES			
Infant Sleep Positioning	1-800-331-7437	www.tomorrowschildmi.org	Information/brochures related to infant sleep positioning.
		www.mihealth.org	Training for professionals, CEUs.
MATERNAL INFANT HEALTH PROGRAM RESOURCES			
Early On Michigan	1-800-EarlyOn Fax 517-668-2505	https://1800earlyon.org/index.php	Early intervention services for infants and toddlers, birth to three years of age with developmental delay(s) or disabilities.
Great Start Collaborative		http://greatstartforkids.org/content/great-start-network	Helps parents find the best early learning settings for their children and helps providers and educators improve the care they give to their children.
ModivCare Solutions (formerly known as LogistiCare Solutions)	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland, and Macomb counties.
Maternal Infant Health Program	Phone #: 1-833-644-6447 Fax #: 517-763-0366	website: http://www.michigan.gov/mihp e-mail address: mihp@michigan.gov	Information regarding MIHP enrollment and operations, including the MIHP Operations Guide, forms, and contact information.
Text4baby		https://ww.text4baby.org	Service providing information for pregnant and postpartum women.
MI CHOICE WAIVER RESOURCES			
Critical Incident Reporting	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://webapp.ciminc.com/CompassMI	Information on critical incident reporting.
Home Delivered Meals Guidelines and Other Required Documents		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program >> MI Choice Waiver Documents and Provider Information	Home Delivered Meals Guidelines, Person-Centered Planning Guidelines, HCPCS Codes, NOC/NOC Code Document, Provider Monitoring Tool, residential and non-residential setting surveys, Self-Determination Guidance
MDHHS Audit Reports	Phone: 517-241-7599	email: MDHHS-AuditReports@michigan.gov	Required audit and any other related submissions.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MI Choice Contract	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://egrams-mi.com/dch/user/home.aspx >> Medicaid/Long Term Care	MI Choice contract template and attachments.
MI Choice Intake Guidelines		View documents: www.michigan.gov/medicaidproviders >> MI Choice Vendor access for Waiver Agencies: https://webapp.ciminc.com/CompassMI	MI Choice Intake Guidelines documents and on-line access.
MI Choice Waiver	517-241-4100	Home and Community Based Services Section 400 S. Pine St. Lansing, MI 48913 E-mail: MDHHS-MiChoice@michigan.gov www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	Information regarding waiver services and regional contact information.
MI Choice Waiver Diversions	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://webapp.ciminc.com/CompassMI	Information for requesting diversion status for an applicant.
MI Choice Waiver Program Provider Monitoring Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://egrams-mi.com/dch/user/home.aspx >> Medicaid/Long Term Care	Document defining procedures and standards used by MDHHS in reviewing agencies and providers.
MI Choice Waiver – Provider Information		www.michigan.gov/medicaidproviders >> MI Choice	Information for MI Choice providers.
MDHHS Quality Management Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913	Document addressing waiver agency quality assurance and improvement for MI Choice.
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Nursing Facility Transition	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 https://webapp.ciminc.com/CompassMI	Information for intent to transition a nursing facility resident to MI Choice.
Waiting List Removal – Adequate Action Notice		www.michigan.gov/medicaidproviders >> MI Choice	MI Choice Waiting List Removal Adequate Action Notice template.
Waiting List Reporting		https://webapp.ciminc.com/CompassMI	Submit data for the waiting list.
MI HEALTH LINK			
Home and Community-Based Services Final Rule (CMS-2249F, CMS-2296F)		http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html	For providers or other interested individuals to access the HCBS Final Rule.
Medicaid State Plan Personal Care Services Individual and Agency County Rates		http://www.michigan.gov/documents/mdch/Individual_and_Agency_Hourly_Rates_Per_County_476167_7.pdf	Information regarding county rates for individual and agency providers of personal care services.
Medicaid State Plan Personal Care Services Payment Schedule		www.michigan.gov/homehelp	Table indicating the minimum schedule when payments should be made for personal care services during the MI Health Link continuity of care period for individuals who were receiving Home Help services through MDHHS.
MI Health Link		www.michigan.gov/mihealthlink >> Providers	Information regarding how providers may participate in MI Health Link.
NON-EMERGENCY MEDICAL TRANSPORTATION			
MDHHS NEMT Database		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Non-Emergency Medical Transportation (NEMT)	This database includes current information pertaining to NEMT reimbursement rates and services.
ModivCare Solutions (formerly known as LogistiCare Solutions)	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland and Macomb counties.
NURSING FACILITY LEVEL OF CARE DETERMINATION			
Community Health Automated Medicaid Processing System (CHAMPS) Level of Care Determination (LOCD)		https://milogintp.michigan.gov	
Level of Care Determination of Field Definitions		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination (under Resources)	

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS County Offices		www.michigan.gov/mdhhs >> Inside MDHHS >> County Offices	
Michigan Medicaid Nursing Facility LOCD Exception Process		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination (under Resources)	
NURSING FACILITY RESOURCES			
Certificate of Need Commission	517-241-3344 fax 517-241-2962	MDHHS Certificate of Need Evaluation Section South Grand Building, 4th Floor 333 S. Grand Ave. Lansing, MI 48913 www.michigan.gov/providers >> Certificate of Need	
Complaints	Hotline: 800-882-6006 fax 517-763-0214	Department of Licensing and Regulatory Affairs Bureau of Survey and Certification Complaint Intake Section PO Box 30838 Lansing, MI 48909 Delivery: 611 W. Ottawa St., 1st Floor Lansing, MI 48913 www.michigan.gov/bsc	To file a complaint against a health care facility. Complaints on quality of care by nursing facilities, hospitals, home health agencies.
Direct Care Worker (DCW) Forms		www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms	MDHHS-5919-A & MDHHS-5919-C; AFC/HFA; Skilled Nursing Facility DCW Wage Pass-Through forms; DCW Frequently Asked Questions
LTC Ombudsman	866-485-9393		Advocacy for nursing facility residents.
MDHHS, Long-Term Care Operations		MDHHS Long-Term Care Operations PO Box 30479 Lansing, MI 48909-7979 E-mail: MDHHS-bedcerts@michigan.gov	Medicaid NF bed certification.
		Email: MDHHS-NFISOLATION@michigan.gov	Medicaid NF isolation bed requests.
MDS RAI Manual		www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> SNF Quality Reporting Program >> MDS 3.0 RAI Manual	Instruction manual for the MDS.
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicare Part D	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Nurse & Medication Aide Trainers and Training Programs	517-896-0511	www.michigan.gov/lara >> Bureaus >> Community and Health Systems >> Nurse & Medication Aide Training Program & Trainers	Questions regarding nurse aide training and testing.
Nurse & Medication Aide Registry	517-284-8961	www.michigan.gov/bchs >> Nurse & Medication Aide Registry	List of certified nurse aides.
Nursing Facility Forms & Instructions, Calculation Examples **(revised per bulletin MMP 24-55)**		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	New Provider Information Packet, cost reporting forms, NF provider list, nurse aide testing reimbursement for facility and individual CNA, Cost-Settled Provider Detail Report (FD-622).
Nursing Facility Rate Setting	517-335-5356 fax 517-335-5443	MDHHS /LTC Reimbursement & Rate Setting Section PO Box 30815 Lansing, MI 48909-7979 Delivery: Elliott-Larsen Building, 4th floor 320 S. Walnut St. Lansing, MI 48913 email address: DARS@michigan.gov website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	Nursing facility rate setting and cost reporting information; New Provider Information Packet; Nursing Facility reimbursement; Skilled Nursing Facility (SNF) DCW Wage Increase Medicaid Fee Schedule.
Michigan Medicaid Nursing Facility Level of Care Determination		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination	Information and forms necessary to complete the Michigan Medicaid Nursing Facility Level of Care Determination to determine eligibility for NF level of care.
Patient Driven Payment Model (PDPM)		www.cms.gov >> Medicare >> Skilled Nursing Facility PPS (under Medicare Fee-for-Service Payment) >> Patient Driven Payment Model	Resources including PDPM overview, fact sheets, and available training.
Payee Registration Helpline	888-734-9749 or 517-373-4111	www.michigan.gov/SIGMAVSS	Enroll with SIGMA Vendor Self Service (VSS) for payment issued outside claims processing.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Pre-Eligibility Medical Expenses (PEME)	517-241-4302 fax 517-241-8556	MDHHS Behavioral and Physical Health and Aging Services Administration Attention: PEME PO Box 30479 Lansing, MI 48909-9634 E-mail: MDHHS-MSA-PEME@michigan.gov	MDHHS review of offsetting unpaid PEME
Quality Measure Initiative (QMI)		Email: MDHHS-NFQMI@michigan.gov Website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities >> Nursing Facility Quality Measure Initiative	Additional resources and contact information related to the nursing facility QMI.
RAI/MDS Coordinator	517-335-2086 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Survey and Certification Division MDS Coordinator 611 W. Ottawa St. Lansing, MI 48933 E-mail: najafih@michigan.gov Website: www.michigan.gov/bsc	Assistance with nursing facility MDS.
State Survey Agency (Nursing Facilities)	517-284-0193 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Survey and Certification 611 W. Ottawa St., 1st Floor Lansing, MI 48933 www.michigan.gov/bsc	NH/SNF federal survey and certification.
Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR)	BSC main phone line: 517-284-0193	Department of Licensing and Regulatory Affairs Bureau of Survey and Certification 611 W. Ottawa St. Lansing, MI 48933 Delivery: 611 W. Ottawa St., 1st Floor Lansing, MI 48913 Email: LARA-BSC-IDR@michigan.gov www.michigan.gov/bsc	For questions regarding completion or timeliness of IDR/IIDR process for long term care facilities.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS OBRA Office	517-241-5881	MDHHS /OBRA Office 5th Floor, Elliott-Larsen Building 320 S. Walnut Lansing, MI 48913	PASARR information, follow-up on submitted DCH-3878 (Level II evaluation).
Department of Technology, Management & Budget (DTMB)		www.michigan.gov/dtmb >> Agency Services >> Travel >> Travel Rates	Approved private vehicle mileage rate information.
Centers for Medicare & Medicaid Services	1-800-633-4227	Centers for Medicare & Medicaid Services 7500 Security Blvd. Baltimore, Maryland 21244 http://www.cms.hhs.gov/Manuals/PBM/list.asp	Medicare Principles of Reimbursement (42 CFR 413), CMS Provider Reimbursement Manual (PRM-15 or Pub 15)
Beneficiary Benefit Plan ID(s) for the DOS, including Patient Pay Amount and MA Redetermination Date (if on file)		Michigan Public Health Institute (MPHI) X12 270/271 Transaction testing information and companion guide: http://mihealth.org >> Trading Partners >> Medicaid Healthplan 270/271 Companion Guide v3.0 >> MPHI Companion Document v3.0 20070312.pdf MI Healthplan Benefits website: https://hpb.mihealth.org >> Create an Account	Electronic Data Interchange (EDI) alternatives are available at no cost through MPHI for nursing facilities to verify Medicaid beneficiary eligibility.
Nursing Home Compare (NHC)		https://www.medicare.gov/nursinghomecompare/search.html	NHC website information used for nursing facility QMI payments.
Special Focus Facility (SFF) List		https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf	Website information for the SFF list.
United States Department of Labor Consumer Price Index		https://www.bls.gov/cpi/	United States Department of Labor Consumer Price Index website information to find the cost-of-living changes for the Owner/Administrator compensation limits.
PHARMACY RESOURCES			
MDHHS Pharmacy Benefit Manager (PBM) 24/7/365	877-624-5204	Prime Therapeutics State Government Solutions, LLC 4300 Cox Rd. Glen Allen, Virginia 23060 Web address: https://mi.primetherapeutics.com	General information, MPPL, Michigan Preferred Drug List (PDL)/Single PDL, claim submission instructions, etc. See Prior Authorization Section of this Directory for additional PBM contact information.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Pharmacy Benefit Manager (PBM)	888-868-9219 Fax: 804-965-7647	Prime Therapeutics State Government Solutions, LLC Michigan Medicaid – Pharmacy Provider Relations Unit 4300 Cox Rd. Glenn Allen, VA 23060 Website address: https://mi.primetherapeutics.com	Pharmacy remittance advice, EFT requests, and other services/inquiries.
Medicaid Health Plan Pharmacy Benefit		www.michigan.gov/MCOpharmacy	Medicaid Health Plan Common Formulary
MAC Pricing Information 9 am - 5 pm EST, M – F	800-327-6226 Fax 888-656-1951	Prime Therapeutics State Government Solutions, LLC Attn.: MAC Department 4300 Cox Rd. Glenn Allen, VA 23060 email address: StateMacProgram@primetherapeutics.com Website address: https://mi.primetherapeutics.com	Maximum allowable cost (MAC) pricing information.
MDHHS Drug Dispensing Fees		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Pharmacy	
Michigan Automated Prescription System (MAPS)		www.michigan.gov/mimapsinfo	Michigan's prescription drug monitoring program. MAPS is used to identify and prevent drug diversion at the prescriber, pharmacy, and patient level.
Refunds, Overpayments	877-624-5204 fax 887-888-6370	Prime Therapeutics State Government Solutions, LLC 4300 Cox Rd. Glen Allen, VA 23060	Instruction regarding how to submit claims, refunds and overpayments.
List of Chronic Conditions for Medication Therapy Management Eligibility		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider-Specific Information >> Pharmacy	
List of Drugs Past CMS Termination Dates		http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html	
List of Rebate-Participating Labelers		https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html	List of approved labelers who have signed rebate agreements with CMS.
List of Participating Entities in 340B Program		https://340bopais.hrsa.gov/coveredentitysearch	

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Continuous Glucose Monitoring Systems, Secondary Payer Coverage		https://mi.primetherapeutics.com/ >> Provider Portal >> Documents >> Fee for Service Drug Coverage >> Continuous Glucose Monitoring Systems, Secondary Payer Coverage	List of approved CGMS and accessories for secondary payer coverage.
Drug Rebate Specialist	Fax 517-241-7816	MDHHS Pharmacy Program Bureau of Medicaid Operations & Quality Assurance PO Box 30479 Lansing, MI 48909-7979 email address: MDHHSPharmacyServices@michigan.gov	PHS and DSH hospitals that bill the 340B prices on their drug claims are excluded from the drug rebates.
National Average Drug Acquisition Cost		https://data.medicaid.gov	
Provider Liaison Meeting Calendar		https://mi.primetherapeutics.com	Schedule of liaison meetings and contact information for questions and submission of agenda items.
Centers for Medicare & Medicaid Services		https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/trp.html	Information on Tamper Resistant Prescription Pad policy.
Vaccines for Children Program		https://www.michigan.gov/documents/mdhhs/Detailed_Flyer_-_Become_a_VFC_Provider_668245_7.pdf	Instruction regarding how to become a Vaccines for Children provider.
PLAN FIRST FAMILY PLANNING			
Plan First Family Planning		Plan First (michigan.gov)	Provider and beneficiary resource for information about eligibility and how to apply for Plan First, an overview of Plan First covered services, links to lists of specific program-covered drug categories, HCPCS/CPT and diagnosis codes, and the Plan First brochure.
PRIVATE DUTY NURSING RESOURCES			
Other Insurance for PDN	Fax 517-335-9422		Submit letters of explanation or EOB when required.
SCHOOL SERVICES PROGRAM			
SSP Administrative Outreach Program Policy Specialist	517-284-1197	SSP Administrative Outreach Specialist MDHHS Program Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
SSP Fee for Service Program Policy Specialist	517-284-1197	SSP Fee for Service Program Policy Specialist MDHHS Program Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit (Fee For Service).
School Services Program		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> School Services Program	Databases, FAQs, cost reporting & training, software information, Random Moment Time Study Results.
TELEMEDICINE			
MDHHS Telemedicine Audio/Visual and Audio-Only Fee Schedules		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Telemedicine	These fee schedules include current service codes that are allowed to be rendered via telemedicine.
MDHHS Bureau of Specialty Behavioral Health Services Telemedicine Database		https://www.michigan.gov/mdhhs/keep-mi-healthy/mentalhealth/reporting	This database includes current service codes that are allowed to be rendered via telemedicine within the Specialty Behavioral Health Services contracted providers.
VISION SERVICES RESOURCES			
Vision Contract Manager		Vision Contract Manager MDHHS /Program Review Division PO Box 30170 Lansing MI 48909	Submit copy of DCH-0893.
Vision Contractor (Classic Optical Laboratories)	888-522-2020 Fax 330-759-8300	Classic Optical 3710 Belmont Ave. PO Box 1341 Youngstown, OH 44501-1341 www.classicoptical.com	Contractor for provision of eyewear frames and lens.
REPORTING FRAUD, ABUSE, OR MISUSE OF SERVICES			
Benefits Monitoring Program (BMP)	855-808-0312	MDHHS Program Review Division Benefits Monitoring Program P.O. Box 30170 Lansing, MI 48909-7979 email: MDHHS-MSA-BMP@michigan.gov	Report potential misutilization of services by Medicaid beneficiaries.
MDHHS Office of Inspector General	1-855-MI-FRAUD (1-855-643-7283)	Michigan Department of Health and Human Services Office of Inspector General PO Box 30062 Lansing, MI 48909-7979 www.michigan.gov/fraud	Report suspected Medicaid provider or beneficiary fraud and/or abuse.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Health Care Fraud Unit	800-242-2873 fax 517-241-6515	Health Care Fraud Division Department of the Attorney General Medicaid Fraud Control Unit PO Box 30218 Lansing, MI 48909 email: HCF@michigan.gov website: www.michigan.gov/ag >> Complaints	Report Medicaid provider fraud.
MDHHS OBRA Office	517-373-8091	MDHHS /OBRA Office 5th Floor, Elliott-Larsen Building 320 S. Walnut St. Lansing, MI 48913	Complaints/concerns about local CMHSP services to nursing facility residents.
Bureau of Community and Health Systems, Allegation Unit (MI Dept. of Licensing and Regulatory Affairs)	517-373-9196	www.michigan.gov/bpl >> File a Complaint	Complaints about licensed healthcare professionals (e.g. physicians, nurses, therapists, NF administrators).
Michigan Department of Civil Rights	800-482-3604		Report violations of handicapper rights.
Michigan Disability Rights Coalition	800-760-4600		
Office of Inspector General of the U.S. Department of Health & Human Services (HHS)	313-226-4258	Office of Inspector General of the U.S. Department of Health & Human Services (HHS) Room 512 – Federal Courthouse Detroit, MI 48226	Report violations of federal law.
U.S. Department of Justice, Office of Civil Rights	800-552-6843		Report violations of handicapper rights.
OTHER HEALTH CARE RESOURCES/PROGRAMS			
Breast & Cervical Cancer Control Program	800-922-6266		Information regarding program services, eligibility, and enrollment.
Centers for Disease Control and Prevention Diabetes Prevention Recognition Program (CDC DPRP) Standards and Operating Procedures		https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf	The DPRP ensures the quality of recognized organizations and provides standardized reporting on their performance. The standards include a detailed definition of glucose testing requirements that assist in the decision of a participant's eligibility for the program.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Children in Foster Care		1. www.michigan.gov/mdhhs >> Adult & Children's Services >> Foster Care >> Forms and Publications 2. http://www.brightfutures.org/mentalhealth/pdf/tools.html >> Pediatric Symptom Checklist 3. http://www.massgeneral.org/psychiatry/services/psc_forms.aspx 4. http://agesandstages.com	1. MDHHS Well Child Exam forms and Psychotropic Medication Informed Consent (DHS-1643) 2. Pediatric Symptom Checklist 3. Pediatric Symptom Checklist in other languages 4. Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
Children's Waiver Program	517-241-5757	MDHHS – BCCHPS Program and Grant Development and Quality Monitoring Division Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Information regarding the Children's Waiver program.
Freedom to Work	Local MDHHS office	Local MDHHS office	Information regarding program eligibility.
Habilitation Supports Waiver for Persons with Developmental Disabilities	517-256-7522	MDHHS - BPHASA Division of Adult Home and Community Based Services Capitol Commons Center, 5th floor 400 S. Pine St. Lansing, MI 48913	Information regarding certification and re-certification of HSW enrollees; and HSW coverages.
Medicare Savings Program	local MDHHS office		Information regarding program eligibility and enrollment.
Medicare	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Mental Health Home-based Program	517-241-5772	MDHHS – BCCHPS Office of the Advocate for Children, Youth and Families Capitol Commons Center, 6th floor 400 S. Pine St. Lansing, MI 48913	Information regarding how to obtain approval of new Mental Health Home-based Programs for children and families.
MIChild	888-988-6300	www.michigan.gov/michild application at: www.michigan.gov/mibridges	Apply at local MDHHS office or online though MI Bridges.
MDHHS Prenatal Smoking Cessation Program	517-335-9750		Information regarding the Smoke-Free Baby and Me intervention model.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MiDPP -Michigan Diabetes Prevention Program	517-373-2818; Fax 517-335-9461	MDHHS Chronic Disease and Injury Control Elliott-Larsen Building 5 N 320 S. Walnut St. Lansing, MI 48933 www.michigan.gov/diabetes	Information on MiDPP provider requirements, beneficiary eligibility and MiDPP locations.
National Autism Center (NAC)		www.nationalautismcenter.org	Information regarding Autism Spectrum Disorder.
Program of All-Inclusive Care for the Elderly (PACE)	517-373-7493	MDHHS Long Term Care and Operations Support Section PO Box 30479 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> Program for All-Inclusive Care for the Elderly (Under Additional Programs & Waivers)	
Special N Support	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment.
Supplemental Security Income (SSI)	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment.
Transitional Medical Assistance	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment.
Brain Injury Services Program	517-241-1685 and 517-241-1680	Local MDHHS office e-mail: MDHHS-MSA-BIS@michigan.gov	Information regarding program eligibility and enrollment.
MISCELLANEOUS CONTACT INFORMATION			
Centers for Disease Control and Prevention (CDC)		www.cdc.gov/growthcharts	Growth charts/graphing documents.
Electronic Health Record (EHR) Incentive Program		www.michiganhealthit.org www.cms.gov/EHRIncentivePrograms	Information regarding the EHR Incentive Program.
Federal Registers		http://www.ecfr.gov	
Sickle Cell Detection and Information	313-864-4406 800-842-0973 Fax 313-864-9980	Sickle Cell Disease Association of America - Michigan Chapter 18516 James Couzens Detroit, MI 48235 http://scdaami.org	Obtain sickle cell tests, tubes, forms, and envelopes. A capillary blood sample may be mailed to SCDAA-MI.
SS and SSI Information Line	800-772-1213		
State of Michigan Operator	517-373-1837		Telephone numbers for State of Michigan offices/employees.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
DMEPOS Liaison Meetings		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/ Prosthetists/DME Dealers	Information on scheduled DMEPOS liaison meetings.
Medical Care Advisory Council (MCAC) Meetings		www.michigan.gov/medicaid >> Program Resources >> Medical Care Advisory Council	MCAC roster, meeting agendas and minutes, and meeting dates.

GLOSSARY APPENDIX

Glossary Term	Definition
Acquisition Costs	The manufacturer's invoice price, minus primary discount, plus a percentage over cost, plus actual shipping costs. Acquisition cost does not include handling fees. (For the specific percentage over cost, refer to the archived policy bulletin MSA 09-62 posted on the MDHHS website.)
Ambulatory Payment Classification (APC)	The Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) is a reimbursement method representing groups of outpatient visits according to clinical characteristics and costs associated with the diagnoses and the procedures rendered known as APCs.
Borderland	A county that is contiguous to the Michigan border and includes several major cities beyond the contiguous county lines.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose and is generally not useful to an individual in the absence of illness, injury or disability.
The Emergency Medical Treatment and Active Labor Act (EMTALA)	42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Encounter	A face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.
Face-to-Face	An encounter that can be either in person or using telehealth (simultaneous audio and visual technology).
Hospital	Hospital means the licensed entity that executed the Hospital Access Agreement, which has the inpatient capacity necessary to provide covered services.
Hospital Based Provider (HBP)	A hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife.
In-Person	An encounter that must be completed with beneficiary and provider physically together in the same location and is not allowed through telehealth.
Medicaid Deductible	Beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS worker to qualify for Medicaid. Previously referred to as Medicaid Spend-down.

Glossary Term	Definition
Medicaid Health Plan (MHP)	A Medicaid managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.
Medical Supplies	Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any non-institutional setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary.
Mobility Related Activities of Daily Living (MRADL)	Daily activities (e.g., grooming, dressing, etc.) the beneficiary is capable of performing with the aid of mobility equipment.
Noncompliance	Failure or refusal to follow instructions related to improving or stabilizing a condition.
Noncovered Service	A medical or health care service that is: ▪ Not covered by Medicaid; ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage; ▪ Provided before or after a beneficiary is an Enrollee in a MHP; or ▪ Non-emergency services for which the Hospital did not secure PA.
Nursing Facility	A nursing home, county medical care facility, State Veterans' Home, or hospital long-term care unit, with Medicaid certification.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body.
Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization or institutionalization.
Outpatient Prospective Payment System (OPPS)	A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (i.e., DRGs for inpatient hospital services, APCs for outpatient hospital services). All services paid under the PPS are classified into groups called Ambulatory Payment Classifications (or APCs). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.
Physician (MD or DO)	An individual licensed under the Michigan Public Health Code (P.A. 368 of 1978) to engage in the practice of medicine or osteopathic medicine and surgery.

Glossary Term	Definition
Practitioner	An MD, DO, Podiatrist, Dentist, Oral-Maxillofacial Surgeon, Physician's Assistant, Advanced Practice Registered Nurse (Certified Nurse Practitioner, Certified Clinical Nurse Specialist, Certified Nurse-Midwife), Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physical Therapist, Psychologist, Occupational Therapist, Optometrist, Speech Therapist, and Audiologist.
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which is providing, has formerly provided, or has been approved to provide medical assistance to a beneficiary pursuant to the medical assistance program.
Public Facility	A public facility is defined at one of the following sections of the Michigan Public Health Code (PA 368 of 1978, as amended): Section 333.2413, Section 333.2415, or Section 333.2421.
Rapid Dispute Resolution Process	The process implemented by MDHHS to administer and resolve claim disputes.
Readmission	Any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital.
Reference Laboratory	An enrolled laboratory that receives a specimen from another referring laboratory for testing and that actually performs the test.
Referring Laboratory	A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.
Sanctioned Provider	A provider who has been suspended, terminated or excluded from furnishing, ordering, or prescribing items or services to Medicaid beneficiaries.
Spend-down	See Medicaid Deductible.
Sterilization	Any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing.
Third Party Liability	A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expense.
Transfer Trauma	Any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient who would be materially detrimental to the physical or mental health of the patient.

Glossary Term	Definition
U & C Charge	The usual and customary charge to the general public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.

FORMS APPENDIX

INTRODUCTION

The Forms Appendix contains all MDHHS forms referenced within the Michigan Medicaid Provider Manual. Detailed instructions are provided for forms that are not self-explanatory (refer to the table below). The bookmarks link to each form. The Forms field in the table below also links to the appropriate forms. Hold the cursor over form number (the hand cursor will turn into a pointing finger). Double click the cursor to access the form directly from the table. Use the navigation arrows to move from page to page and form to appendix.

All forms are also available on the MDHHS website (refer to the Directory Appendix for website information). Most forms are available in PDF format as well as in a downloadable Word-enabled format.

Form Number	Form Name
MSA-2218	Acknowledgment of Receipt of Hysterectomy Information
DHS-390	Adult Services Application
BPHASA-2210	Attestation to the Appropriateness of the Qualified Clinical Trial
MSA-1302	Benefits Monitoring Program Referral
MSA-1550	Beneficiary Verification of Coverage
MSA-4240	Certification for Induced Abortion
MSA-1326	Certified Nurse Aide Training Reimbursement
MSA-1576	Complex Care Prior Approval-Request/Authorization for Nursing Facilities
MSA-1653-D	Complex Seating and Mobility Device Prior Approval-Request/Authorization
MSA-1959	Consent for Sterilization

Form Number	Form Name
MSA-0725	CSHCS Application for Payment of Health Insurance Premiums
MSA-1680-B	Dental Prior Approval Authorization Request
MSA-0892	Documentation of Medical Necessity for the Provision of Contact Lenses
DCH-1401	Electronic Signature Agreement
MSA-2081	Genetic and Molecular Laboratory Test Authorization Request
MSA-181	Home Health Aide Prior Approval Request/Authorization
MSA-204	Home Help Agency Caregiver Enrollment Authorization
MSA-1904	Home Help Agency Invoice
HASA-2104	Home Help Agency Provider Employment Requirements
BPHASA-2207	Home Help Billing for Hospital Admission Date
MSA-2565-C	Hospital Newborn Notice
BPHASA-2421	Live-In Caregiver Attestation
MSA-1755	Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation
MSA-4114	Medical Eligibility Report (MERF)
BPHASA-2401	Medical Justification for Enteral Therapy
DHS-54A	Medical Needs
DCH-3878	Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification (For Use in Claiming Exemption Only)

Form Number	Form Name
BPHASA-2428	Michigan Recuperative Care Provider Attestation
MSA-1656	Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices
MSA-1656 – Addendum A	Mobility/Seating
MSA-1656 – Addendum B	Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs
MSA-1324	Nurse Aide Training and Testing Program Interim Reimbursement Request
MSA-0832	Nursing Facility Isolation Bed Request
MSA-115	Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization
MSA-6544-B	Practitioner Special Services Prior Approval – Request/Authorization
DCH-3877	Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual/Developmental Disability/Related Conditions Identification)
MSA-0732	Private Duty Nursing Prior Authorization – Request for Services
MDHHS-5405	Provider Electronic Signature Agreement Cover Sheet
MSA-0891	Provision of Low Vision Services and Aids Support Documentation
BPHASA-2427	Recuperative Care (RC) Prior Authorization (PA) Request Data
MSA-1580	Request for Authorization of Private Room Supplemental Payment for Nursing Facility
DCH-0078	Request to Add, Terminate or Change Other Insurance

Form Number	Form Name
SAMPLE 1	(Sample of) Continued Stay Notice of Non-Coverage
SAMPLE 2	(Sample of) Notice of Non-Coverage for Inpatient Hospital Admission
SAMPLE 3	(Sample of) Care Coordination Agreement
SAMPLE 4	(Sample of) Paper Remittance Advice
SAMPLE 5	(Sample of) Notification of Upcoming End Date for Electronic Visit Verification Live-In Caregiver Attestation Documentation Letter
MSA-1653-B	Special Services Prior Approval – Request/Authorization
DCH-0893	Vision Services Approval/Order

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Health and Human Services

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

_____

(Recipient or Representative Signature) (Date)

_____

(Interpreter Signature, if required to inform the recipient of the above information) (Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

_____

(Physician Signature) (Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

DHS-390, ADULT SERVICES APPLICATION

Michigan Department of Health and Human Services
(Revised 10-21)

Note: If you need help to complete this application, please indicate what kind of help you need.

☐ Bilingual Interpreter ☐ Sign-language interpreter for the deaf
☐ Other (specify)

FOR DEPARTMENTAL USE ONLY

1. Case Name	2. Log Number	3. Recipient ID Number
4. County	5. Date	
6. Worker	7. Worker Phone Number	

CLIENT INFORMATION

8. Full Name of Person Needing or Requesting Services

9. Date of Birth (MM/DD/YYYY)	10. Social Security Number

11. Address (Number, Street, City, State, Zip Code)

12. Phone or Cell Number	13. TTY Number (Teletype for the deaf)

SECTION A – DEPARTMENT PROGRAMS: Below is a brief description of the services provided by the Department. Check the box or boxes which describe the services you need or problems where you desire help.

1. ☐ **Home Help**
   Services to help pay for someone to assist with personal care and housekeeping.
2. ☐ **Adult Community Placement**
   Services for adults who can no longer remain in their own homes. Includes help finding an adult foster home or home for the aged and services for people living in these settings.
3. ☐ **Other Services**
   Nonpayment services to help adults stay safe in their own homes. Services may include information and referral to other community resources.

IF YOU OR SOMEONE YOU KNOW IS IN NEED OF PROTECTIVE SERVICES, CONTACT CENTRALIZED INTAKE FOR ABUSE OR NEGLECT AT 855-444-3911.

SECTION B – CURRENT SITUATION: Check all boxes that apply to you.

1. Your Status as a Recipient
   a. ☐ Medicaid (MA) recipient
   b. ☐ Medicaid application pending
   c. ☐ Supplemental Security Income (SSI) recipient
   d. ☐ MI Choice Waiver recipient
   e. ☐ PACE recipient
   f. ☐ MI Health Link recipient

g. ☐ Community Mental Health (CMH) recipient
h ☐ Food Assistance recipient
i. ☐ Family Independence Program (FIP) recipient
j. ☐ State Disability Assistance (SDA) recipient
k. ☐ Veteran Affairs recipient
l. ☐ Other

2. Living Arrangement (Check all boxes that apply to you and answer related questions)
   a. ☐ Alone
   b. ☐ With spouse (If married answer questions below.)
      Is spouse disabled? ☐ Yes ☐ No
      Is spouse working? ☐ Yes ☐ No
      Full name of spouse Date of Birth
   c. ☐ With children under age 18. How many? _____
   d. ☐ With others (relatives and non-relatives) How many? _____
   e. ☐ Live in adult foster care facility, home for the aged.
   f. Is client in a hospital or nursing home? ☐ Yes ☐ No
   g. Does the recipient have a guardian? ☐ Yes ☐ No
      Name of guardian
   h. Is a caregiver/provider already identified? ☐ Yes ☐ No

Read the following statement, sign, and date the application.

I wish to apply for one of the adult services programs. I certify that the information I have given is correct. By signing, I acknowledge that I have read and agree to the rights, responsibilities, and important things to know described in Section C of this application.

Signature of Client or Authorized Representative Date

SECTION C – SERVICES APPLICATION RIGHTS, RESPONSIBILITIES, AND IMPORTANT THINGS TO KNOW

Instructions:

- Be sure to read this information. It describes your rights and responsibilities.
- **Keep this copy for your records.**
- If you have any questions regarding your rights and responsibilities or any information provided in this section, contact the adult services worker.

1. YOU HAVE THE FOLLOWING RIGHTS:

Application: You have the right to apply for adult services programs at any time. Your application must be approved or denied within 45 days from the day your referral is received by MDHHS. When applying for Medicaid funded programs such as Home Help, you will not be approved until you have active Medicaid. If you need financial or medical assistance, another application is needed. You have the right to be notified in writing of the approval or denial of services and to be treated fairly and with dignity in all dealings with the department.

Non-discrimination: If you believe you have been discriminated against because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or disability or genetic information that is unrelated to the person's eligibility, you have the right to file a complaint with the following:

- Michigan Department of Civil Rights: 800-482-3604
- U.S. Department of Health and Human Services: 202-619-0403

Hearings: If you believe you have been treated unfairly or a mistake has been made concerning your case, you have a right to request an administrative hearing with the Michigan Office of Administrative Hearings and Rules (MOAHR) within 90 days of the action. You will be given the opportunity to explain your case to an impartial administrative law judge. You may request a hearing in any written form or you may submit the DCH-0092, Request for Hearing form, which is available online at https://www.michigan.gov/mdhhs/0,5885,7-339-71547_4860_78446_78448-16825--,00.html. All requests must be signed and dated by you or your authorized representative.

Voter Registration: If you are not registered to vote, you have the right to register.

Explanation About the Food Assistance Program (FAP):

- You may be eligible to receive food benefits.
- You may apply for the Food Assistance Program at your local MDHHS office. If you have questions, contact the Eligibility Specialist assigned to your Medicaid case.

2. **YOU HAVE THE FOLLOWING RESPONSIBILITIES:**

- You must provide MDHHS with correct and complete information about your situation. The information you give may need to be verified.
- You must report **any** changes regarding your case to your adult services worker **within ten business days** of the change. This includes, but is not limited to, changes in your medical condition or care needs, living arrangements, marital status, change in providers, hospitalizations or nursing home stays (services cannot be paid while you are in the hospital or nursing home) or any other change which may affect your eligibility or the amount of benefits.
- If you neglect or refuse to report required changes, or make false or misleading statements, you can be prosecuted for fraud. If you have any doubt about whether you should report a change, contact your adult services worker at the local MDHHS office.

Repayment of Benefits: I understand that if benefits are overpaid for any reason, the overpayment amount received will have to be repaid. In addition, if intentional misrepresentation or concealment of material information caused the overpayment, the responsible party/parties, including the provider of care, may be prosecuted for fraud.

Release of Information: I authorize the MDHHS to provide notice to my care provider(s) when Home Help services or Adult Community Placement has been authorized, when there are changes in the authorization amount previously given to the provider or when my case is closed.

3. **IMPORTANT THINGS TO KNOW:**

a. Home Help and Adult Community Placement are Medicaid funded programs. As a Home Help recipient, I am responsible for any costs not paid by MDHHS, including benefits which may have been authorized but for which I no longer qualify due to Medicaid ineligibility. Adult Foster Care/Home for the Aged providers are responsible for returning supplemental payments they receive when a client is not eligible.

b. I am not eligible for Home Help services prior to being certified by a Medicaid medical professional. Certification of need is provided on the DHS-54A, Medical Needs form.

c. I understand that my Home Help provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) and undergo a criminal history screening. Payment will only be made to the provider who is enrolled and approved by MDHHS to provide services for me.

   Adult Foster Care/Homes for the Aged providers must register in the Statewide Integrated Governmental Management Application (SIGMA) and enrolled in the Bridges system to receive payment.

d. Payment for Home Help services cannot be approved prior to (1) the medical professional's signature date on the DHS-54A and (2) the provider enrollment and approval date.

e. I understand that my Home Help or Adult Community Placement case will be reviewed every six months to determine if I continue to qualify for services.

f. I have the right to choose my Home Help provider. I understand that my provider is not employed by the State of Michigan or MDHHS. I am considered the employer and have the right to hire or fire my provider.

g. I understand that Home Help services and Adult Community Placement are benefits to me and earnings to my provider. Home Help checks may be addressed to both the client and provider (dual party). I am responsible to endorse the check and give it to my provider. If I hire an agency or reside in an adult foster care home, checks will be sent directly to the agency on my behalf.

h. I understand that payments cannot be approved for periods of time that I am in a hospital, nursing home or rehabilitation facility as this is considered duplication of Medicaid services. Payment can be approved for services provided on the day I am discharged from the hospital, nursing home or rehabilitation facility but not the day I am admitted.

i. If a reported change results in a reduction or termination of benefits, I will be notified in writing of the negative action.

j. I understand that my individual Home Help provider must record the tasks they provide for me electronically in CHAMPS. An exception may be granted for my provider to submit a paper services verification if they meet certain criteria.

k. I understand that my individual Home Help provider must submit an electronic or paper services verification before they can be paid. The Adult Foster Care/Homes for the Aged provider must submit a monthly claim electronically in the Adult Services Authorized Payment system.

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.
Call 517-241-2112 (TTY 771).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 517-241-2112 (TTY 771).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 517-241-2112 (رقم هاتف الصم والبكم: 771).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 517-241-2112 （TTY 771）
Syriac (Assyrian)	ܡܫܘܬܦ: ܐܢ ܐܢܬ ܡܡܠܠ ܠܫܢ̈ܐ ܐܚ̈ܪ̈ܢ̈ܐ، ܐܝ ܒܗ ܫܝ ܐܦ̈ܫܪ̈ܝ ܠܟ ܠܫܢ̈ܐ ܕܡܬܪ̈ܓܡ̈ܢ̈ܐ ܒܠܫ̈ܢ̈ܐ ܕܡܬ̈ܐ ܕܥܙ̈ܪ̈ܐ ܠܟ ܒܠܐ ܡܚ̈ܐ. ܩ̈ܠ ܠ 517-241-2112 (TTY 771) ܡܢ ܫ̈ܥ̈ܐ ܕ̈ܝ̈ܢ̈ܐ ܠ̈ܡ̈ܐ.
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 517-241-2112 (TTY 771).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 517-241-2112 (TTY 771).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 517-241-2112 (TTY 771)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১517-241-2112 (TTY ১771).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 517-241-2112 (TTY 771).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 517-241-2112 (TTY 771).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 517-241-2112 (TTY 771).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。517-241-2112（TTY 771）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 517-241-2112 (телетайп 771).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 517-241-2112 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 771).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 517-241-2112 (TTY 771).

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
PO Box 30195
Lansing, MI 48909

517-284-1018 (Main), [TTY number—if covered entity has one], 517-335-6146 (Fax), [Email]

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

Attestation to the Appropriateness of the Qualified Clinical Trial

Instructions for BPHASA-2210

General Information

BPHASA-2210 is a mandatory attestation form on the appropriateness of a qualified clinical trial in which a Medicaid beneficiary is participating. This form is required for coverage of routine patient costs for items and services furnished in connection with the beneficiary's participation in a clinical trial.

The completed BPHASA-2210 must be submitted with:

- Claims - Submit via CHAMPS, Document Management Portal, with claims for routine patient costs furnished in connection with a qualifying clinical trial (Refer to the Billing & Reimbursement for Professionals Chapter of the MDHHS Medicaid Provider manual for additional information)
- Prior Authorization (PA) Requests - Submit via CHAMPS direct data entry with PA requests for items and services provided in connection with a qualifying clinical trial that require PA (Refer to the General Information for Providers Chapter of the MDHHS Medicaid Provider Manual for additional information)

For additional information on how to submit documentation with claims or requests for prior authorization, refer to Community Health Automated Medicaid Processing System (CHAMPS) (michigan.gov)

Completion Instructions

BPHASA-2210 must be signed by both:

- Principal investigator of the specified clinical trial, AND
- Health care provider
    - May also be the principal investigator,
    - Qualified health care providers include licensed providers that are part of the beneficiary's health care team such as, but not limited to, the beneficiary's primary care, specialty, treating, referring, or ordering provider.

Questions should be directed to Provider Support at ProviderSupport@michigan.gov

MEDICAID ATTESTATION FORM ON THE APPROPRIATENESS OF THE QUALIFIED CLINICAL TRIAL

Participant	
Participant Name	
Medicaid I.D.	
Qualified Clinical Trial	
National Clinical Trial Number (from clinicaltrials.gov)	
Principal Investigator Attestation	
Principal Investigator Name	
☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating. ☐ The Principal Investigator is also the Health Care Provider and hereby attests to the appropriateness of the qualified clinical trial in which the individual identified above is participating	
Signature	Date
Insert Signature of Principal Investigator	Insert Month, Day, Year
Health Care Provider Attestation	
Health Care Provider Name	
☐ I hereby attest to the appropriateness of the qualified clinical trial in which the individual identified above is participating.	
Signature	Date
Insert Signature of Health Care Provider	Insert Month, Day, Year

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-0193. Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, political beliefs or disability.

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

BENEFITS MONITORING PROGRAM REFERRAL

SECTION 1 – Purpose of Submission

☐ PCP Designation ☐ Specialty Referral ☐ Discharge from Practice

SECTION 2 – Beneficiary Information

Beneficiary Name (Last, First, Middle)			mihealth Card Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 3 – Referring Provider Information

Provider Name			Individual NPI Number	Specialty
Organization Name (If applicable)			Organization NPI Number	
Business Address			Are you the PCP? ☐ **YES** ☐ **NO**	
City	State	ZIP Code	Telephone Number	Fax Number

SECTION 4 – Referred Provider Information

Provider Name			Individual NPI Number	Specialty
Organization Name (If applicable)			Organization NPI Number	
Business Address			Telephone Number	Fax Number
City	State	ZIP Code	Anticipated Duration of Need ☐ Acute/Short-Term ☐ Chronic/Long-Term	

SECTION 5 – Drugs Subject to Abuse

MDHHS must authorize all prescribers of drugs subject to abuse for BMP-enrolled beneficiaries. Do you anticipate a need for the referred provider to prescribe medications in these classes?

☐ **YES** ☐ **NO** ☐ **Unable to determine**

Include the beneficiary's current medication list with form submission.

SECTION 6 – Additional Information/Comments (including diagnoses)

Provider Signature	Date of Authorization

Benefits Monitoring Program Referral (MSA-1302)
Instructions for Completion and Submission

General Instructions

This form should ONLY be used for beneficiaries enrolled in the Benefits Monitoring Program (BMP). Enrollment may be verified through the CHAMPS Eligibility Inquiry response as additional information. The form is to be completed by the beneficiary's BMP Authorized Provider(s). For additional program information, refer to the Michigan Medicaid Provider Manual (Beneficiary Eligibility Chapter, Benefits Monitoring Program Section) available on the MDHHS website.

MDHHS requests that the MSA-1302 be typewritten to facilitate processing.

Form Completion

Section 1	Check the appropriate box to communicate purpose of the submission.
Section 2	Beneficiary Information.
Section 3	Referring (or Primary Care) Provider Information.
Section 4	Referred Provider Information. Note: This section may be left blank when making a PCP designation only.
Section 5	Check the appropriate box to communicate the anticipated need for MDHHS to authorize the referred provider to write prescriptions for drugs subject to abuse for this beneficiary. Include the beneficiary's current list of medications with form submission.
Section 6	Fill in the reason for referral, including diagnosis. Include any additional information that would assist in MDHHS review. When using this form to communicate a discharge from practice, include a copy of the communication from your office to the patient for MDHHS records.

Copy Distribution

- Original – Referring Provider File
- Copy – Referred Provider
- Copy – Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration,
  Benefits Monitoring Program

Form Submission

The MSA-1302 and any supplemental information (e.g. medication list, medical records, forged prescriptions, etc.) must be mailed or faxed to:

MDHHS – Behavioral and Physical Health and Aging Services Administration
Benefits Monitoring Program
PO Box 30170
Lansing, MI 48909

Fax Number: (517) 335-0075

The MDHHS Program Review Division may be reached via telephone at (800) 622-0276.

AUTHORITY: Title XIX of the Social Security Act.
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

BENEFICIARY VERIFICATION OF COVERAGE

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

I understand that Medicaid, Healthy Michigan Plan, or MIChild only covers payment for elective abortions under limited circumstances.

These are:

- ☐ Elective abortion to terminate a pregnancy to save the life of the mother,
- ☐ Elective abortion to terminate a pregnancy that was the result of rape, or
- ☐ Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid, Healthy Michigan Plan, or MIChild coverage for an elective abortion based upon the circumstance that I have checked above. I understand that if I have given falseinformation to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Michigan Department of Health and Human Services (MDHHS) office or to a police agency when appropriate.

Beneficiary Name (typed or printed)			Beneficiary Signature	
Beneficiary Address				
City	State	ZIP Code	Date Signed	mihealth card

WITNESSED BY:

Witness Name (typed or printed)			Witness Signature
Witness Address			
City	State	ZIP Code	Date Signed

Authority: Title XIX and Title XXI of the Social Security Act. **Completion:** Is Voluntary, but is required if payment from the Medicaid, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

CERTIFICATION FOR INDUCED ABORTION

Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration

Medicaid, Healthy Michigan Plan, or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a copy of the completed form with the claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 800-292-2550 or e-mail ProviderSupport@michigan.gov .

Beneficiary Name	mihealth Number	Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)	City	State	ZIP Code

Appropriate box **must** be checked for payment to be made.

By signing below, I certify that:

☐ **the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)**

_____

_____

_____

_____

☐ **the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.**

In cases of rape or incest, was a police report filed?
☐ **YES** ☐ **NO** (If **NO**, explain)

If appropriate, was a report filed with the local MDHHS office?
☐ **YES** ☐ **NO** (If **NO**, explain)

NOTE **Payment for service is not dependent upon a report being filed with the police or the local MDHHS office.**

Physician Name (Type or Print)			Handwritten Signature of Physician	
Address (No. & Street, Ste., etc.)				
City	State	ZIP Code	Date Signed	Provider NPI Number

Authority: Title XIX and Title XXI of the Social Security Act. **Completion**: Is voluntary, but is required if payment from Medicaid, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Michigan Department of Health and Human Services

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Aide Training Reimbursement

PURPOSE: The Certified Nurse Aide (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name	First Name	Middle Initial
Social Security Number	Birthdate	Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Aide).

TRAINING: *(Attach receipts)*

Approved Program Name: _____ Amount: $ _____

Location: _____ Date of Payment: _____

Completion Date of Training: _____

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Knowledge Test

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Site: _____ Date: _____ Amount: $ _____

Rescheduling Fee (No-Show)

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Date: _____ Amount: $ _____

Initial Registration Fee Date: _____ Amount: $ _____

Registration Document Renewal Date: _____ Amount: $ _____

Check appropriate box, sign and date*:*

☐ **I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.**

☐ **I have received payment from another source for the listed expenses:**

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

Amount: $_____ Date: _____ Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider NPI Number: _____ LARA - BCHS License Number:_____

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Michigan Department of Health and Human Services

COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION FOR NURSING FACILITIES

PRIOR AUTHORIZATION NUMBER

Fax: MDHHS Program Review Division (517) 241-7813

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

SECTION I:

Provider's Name	NPI Number		Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)			Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex ☐ M ☐ F	Birth Date	mihealth Card Number

SECTION II: CARE STAFFING AND SUPPLIES

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	$ _____ Per hour	$ _____
LPN _____ Hours Per Day	$ _____ Per hour	$ _____
Aide _____ Hours Per Day	$ _____ Per hour	$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1.	$ _____ Per day	$ _____
2.	$ _____ Per day	$ _____
3.	$ _____ Per day	$ _____
4.	$ _____ Per day	$ _____
TOTAL		$ _____

SECTION III: ADDITIONAL COMMENTS

(250-Character Limit)

SECTION IV: PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

_____ _____

Provider Signature Date

MDHHS USE ONLY

Review action: APPROVED ☐ INSUFFICIENT DATA ☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED ☐		Consultant remarks	
Start Date	**End Date**	**Units – Number of Days**	**Total Daily Rate**
			$

_____ _____

Consultant Signature Date

Authority: Title XIX of the Social Security Act
Completion: Completion is required for Medicaid reimbursement.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Complex Seating and Mobility Device Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new complex seating or mobility devices submit with a completed Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices" form (MSA-1656).

MDHHS requests that the MSA-1653-D be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. • For repairs or parts, complete MSA-1653-D. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter brand name, model catalog or part number. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter a complete description of the item requested.
Box 22	Enter the HCPCS Procedure Code.
Box 23	Enter the applicable HCPCS Modifier.
Box 28	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 29	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS – Behavioral and Physical Health and Aging Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS – Behavioral and Physical Health and Aging Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

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The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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Michigan Department of Health and Human Services

Complex Seating and Mobility Device Prior Approval - Request/Authorization

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	3. NPI NUMBER		4. PHONE NUMBER
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			6. FAX NUMBER
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.			
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)			13. PHONE NUMBER
14. OTHER INSURANCE NAME	15. POLICY NUMBER		16. FAX NUMBER
17. AUTHORIZATION TYPE: ☐ **NEW WHEELCHAIR/REPLACEMENT** ☐ **REPAIR** ☐ **RENTAL ONLY**			18 **MSA-1656 SUBMITTED ON**

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21.DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE? YES	26. NO	27. DATE LAST REPLACED (MM/DD/YYYY)
01							☐	☐	
02							☐	☐	
03							☐	☐	
04							☐	☐	
05							☐	☐	
06							☐	☐	
07							☐	☐	
08							☐	☐	
09							☐	☐	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

28. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	29. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

30. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

31. DME PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

DME'S SIGNATURE DATE

ADDITIONAL DME'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED

33. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE

Michigan Department of Health and Human Services

Complex Seating and Mobility Device
Prior Approval - Request/Authorization

Additional Page (Use only if requesting additional mobility items)

Beneficiary Name: _____ Mihealth Number: _____

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21. DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE?		27. DATE LAST REPLACED
							YES	NO	(MM/DD/YYYY)
10							☐	☐	
11							☐	☐	
12							☐	☐	
13							☐	☐	
14							☐	☐	
15							☐	☐	
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28							☐	☐	
29							☐	☐	
30							☐	☐	
31							☐	☐	
32							☐	☐	
33							☐	☐	
34							☐	☐	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

CONSENT FOR STERILIZATION

Michigan Department of Health and Human Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____. When I first asked for the
(Doctor or Clinic)

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)

hereby consent of my own free will to be sterilized by

_____
(Name of Doctor and Professional Degree)

by a method called _____ .

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____ Date: _____
(Signature of Person Giving Consent) *(Month / Day / Year)*

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
(Interpreter's Signature) *(Month / Day / Year)*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ _____
(Signature of person obtaining consent) *(Date)*

_____
(Facility)

_____
(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ **on** _____
(Name of individual to be sterilized) *(Date of sterilization)*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)
to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery: _____
  (describe circumstances)

_____

_____ Date: _____
(Signature of Physician and Professional Degree) *(Month / Day / Year)*

INSTRUCTIONS TO COMPLETE CONSENT FOR STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)

Application for Payment of Health Insurance Premiums

Please complete as many fields as possible in the application. In addition, a complete application will include:

- ☐ Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
- ☐ Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
- ☐ Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
- ☐ Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

Mail this application and attachments to:
MDHHS/CSHCS
Insurance Specialist
PO Box 30734
Lansing, MI 48909

OR

Fax: 517-241-8970

For questions call:
Family Phone Line: 1-800-359-3722 and ask for the Insurance Specialist

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)	2. CSHCS ID Number
3. Client's Contact Phone Number - -	4. Client's Date of Birth (MM/DD/YYYY) / /
5. Client's Email Address	6. Client's Preferred Contact Method ☐ **EMAIL** ☐ **PHONE**

SECTION TWO – Insurance Information

Is this case for:

- ☐ **Employer-Based Insurance**
- ☐ **Marketplace Insurance Policy**
- ☐ **Medicare Part B**
- ☐ **Medicare Part D (Prescription Drug Coverage)**
- ☐ **COBRA**
- ☐ **Other:**

7. Is insurance coverage through employer? ☐ **YES** ☐ **NO**	8. Name of employee (if applicable)
9. Name of employer (if applicable)	10. Name of insurance contact person
11. Phone number of insurance contact person ( )	12. Name of insurance company
13. Insurance contract number/group number	14. Premium cost per month $.
15. How many people are covered by this policy (including policy holder)?	16. Date next premium is due / /
17. Date of contract renewal *(when rate could change)* / /	
18. Name and address of company where premium payments are to be sent:	
19. Describe any financial circumstances that should be considered when evaluating this application?	

SECTION THREE – COBRA Information (If applicable)

20. Reason COBRA was offered OR may be available:	
21. Date of qualifying event: / /	22. Date of COBRA notice to employee: / /
23. Date COBRA election form was signed (if applicable) / /	24. Has first COBRA payment been made? ☐ **YES** ☐ **NO** If yes, list date: / /

SECTION FOUR – Health and Medical Information

25. What is the client's CSHCS covered diagnosis?			
26. What does the health insurance cover:	☐ **HOSPITAL**	☐ **DOCTOR VISITS**	☐ **PRESCRIPTIONS**
	☐ **VISION**	☐ **DENTAL**	
27. What are the expected future medical needs for the CSHCS client?			

28. Are there other health insurance coverages for which the client might be eligible (e.g. Medicare Part B, Medicare Part D, other private health insurance, etc)? ☐ **YES** ☐ **NO**
Explain:

29. Additional Comments:

SECTION FIVE – Verification and Signature

☐ **By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.**
☐ **I understand that I may need to show proof of this information.**
☐ **I understand that the information shared might relate to HIV, ARC, or AIDS if the Client has those conditions.**

Signature of Legally Responsible Party or Adult Client **Date Signed**

_____

MDHHS USE ONLY

MDHHS Action ☐ **APPROVED** ☐ **DENIED**	
	MDHHS Signature **Date**

AUTHORITY:	Title V of the Social Security Act.
COMPLETION:	Is Voluntary but is required if CSHCS program services are desired.

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.

Call 800-359-3722 (TTY users call 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-359-3722 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-359-3722 (رقم هاتف الصم والبكم:-TTY:711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-359-3722（TTY:711）
Syriac (Assyrian)	ܐܝܟܐ ܕܡܬܡܠܠ ܐܢܬ ܣܘܪܝܝܐ، ܐܝܟ ܒܐ ܐܢ ܐܬ ܙܒܢ ܠܟ ܒܠܝܫܢ ܕܓ

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- Provides free aids and services to people with disabilities to communicate with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need the above services, contact the MDHHS Section 1557 Coordinator.

If you believe that MDHHS has failed to provide the above services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: MDHHS Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the MDHHS Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),
MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST
Instructions for MSA-1680-B

The Dental Prior Approval Authorization Request form (MSA-1680-B) must be used by dental practices and community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers) to request prior authorization (PA) for individuals enrolled in **Medicaid Fee-for-Service** and/or **Children's Special Health Care Services (CSHCS)**. For beneficiaries enrolled in Healthy Kids Dental, Medicaid Health Plans, or Integrated Care Organizations, providers must contact the assigned plan for authorization requirements.

The status of a PA request may be reviewed in CHAMPS. Additionally, providers will receive a PA determination letter. Approved services must be completed before the PA period ends. To request an extension, the provider must submit a copy of the determination letter and required documentation within 15 days prior to the end date of the current authorization. If the original PA is over one year old, a new PA request must be submitted.

For complete information on covered services, PA and documentation requirements, refer to the Dental chapter of the MDHHS Medicaid Provider Manual, and Michigan Medicaid Approved Policy Bulletins located at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Form Completion: MDHHS requires that the MSA-1680-B be typewritten.

BOX #	INSTRUCTIONS
1 - 5	If submitting a request via CHAMPS direct data entry (DDE), the provider may skip #1 – 5, and start form at box #6.
1 - 2	Enter the Medicaid enrolled provider's organization name and NPI. Previously referred to as Group NPI.
3	Enter the servicing location to which PA correspondence should be mailed, including determination letters and requests for additional clinical information.
4 - 5	Enter the Medicaid enrolled rendering/servicing provider's name and NPI.
6	Enter contact information for an individual in the provider's office that the Program Review Division can contact with questions regarding the PA request.
7 - 11	Enter the beneficiary's name, **mihealth** card number, phone number, date of birth, and sex. The information should be taken directly from the **mihealth** card and verified in CHAMPS.
12	Enter the beneficiary's diagnosis code(s) and description(s) that relate to the service being requested. For CSHCS covered services, dental providers are required to submit the beneficiary's CSHCS qualifying diagnosis.
13	Indicate the dental service category being requested; if not listed, describe under Other. If CSHCS services are being requested, refer to the CSHCS Section, Dental Chapter of the MDHHS Medicaid Provider Manual.
14	Complete the dental chart for each tooth using the Charting Key. For CSHCS requests, additionally document whether each tooth is erupted, partially erupted, or unerupted, as well as the presence of supernumerary teeth. Refer to American Dental Association (ADA) guidelines for designation of supernumerary teeth.
15	If diagnostic images are required by policy, confirm that they are attached to the request. Additionally, enter the date the images were taken and specific tooth number(s) for crowns, dental implants, impacted teeth, bridges, and teeth extracted since the images were taken. To determine services requiring dental images/radiographs, refer to the Dental chapter of the MDHHS Medicaid Provider Manual, and Michigan Medicaid Approved Policy Bulletins located at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.
16 – 17	Complete for requests for periodontal services. Confirm attachment of a comprehensive periodontal charting, periodontitis staging and grading. Refer to American Academy of Periodontology (AAP) guidelines for periodontal diagnosis and classification. Thorough completion of sections 16 – 17 satisfies the requirement for inclusion of the beneficiary's clinical record.
18 – 19	Document any other pertinent dental or medical history. Use box #19 for additional PA related comments.
20 – 23	Complete one line for each CDT procedure code requested. For periodontal services, each quadrant must be entered on a separate line.
24	Printed name, signature and date are required, attesting to the Provider Certification. Signature of a licensed dentist or dental therapist is required.

Form Submission:

PA request forms for all eligible Medicaid and CSHCS beneficiaries must be submitted via direct data entry, faxed, or mailed to:

Michigan Department of Health and Human Services, Dental Prior Authorization
P.O. Box 30154
Lansing, MI 48909
Fax: (517) 335-0075

If submitting electronically, the completed MSA-1680-B must be uploaded along with the supporting clinical documentation required and diagnostic dental images/radiographs if required by policy.

The status of a PA request can be checked via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov. Questions regarding PA should be directed to the Program Review Division at **1-800-622-0276.**

Michigan Department of Health and Human Services

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Submit in CHAMPS via Direct Data Entry (DDE) https://milogintp.michigan.gov or FAX: 517-335-0075

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

NOTE: IF SUBMITTING VIA CHAMPS DIRECT DATA ENTRY, SKIP TO BOX #6

1. Requesting Provider Name (Organization/Group) If not applicable, enter Individual.	2. Organization NPI (previously known as Group) If not applicable, enter Individual.
3. Provider's Servicing Location (for PA correspondence) Street Address	City State ZIP Code
4. Rendering/Servicing Provider Name (Last, First, Middle Initial)	5. Rendering/Servicing Provider NPI
6. Provider Office Contact Information Name: Phone Number: ( ) - Email	
7. Beneficiary Name (Last, First, Middle Initial)	12. ICD Diagnosis Code and Description:
8. **mihealth** Card Number	9. Beneficiary Phone Number ( ) -
10. Date of Birth / /	11. Sex ☐ M ☐ F

13. Dental Services Being Requested

Under 21 ☐ Yes ☐ No
CSHCS ☐ Yes ☐ No
Orthodontics ☐ Yes ☐ No
Adult ☐ Yes ☐ No
Periodontics ☐ Yes ☐ No
Other

14. Complete the required dental chart using the charting key.

Charting Key:
C = Crown
V = Impacted
I = Implant
X = Missing
P = Pontic
/ = To be extracted

1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
			A	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**				
			T	**S**	**R**	**Q**	**P**	**O**	**N**	**M**	**L**	**K**				
32	**31**	**30**	**29**	**28**	**27**	**26**	**25**	**24**	**23**	**22**	**21**	**20**	**19**	**18**	**17**

For CSHCS Requests Only Additionally Indicate:
E = Erupted
PE = Partially Erupted
U = Unerupted

Document Presence of Supernumerary Teeth:

15. Are diagnostic images (if required by policy) attached? ☐ Yes ☐ No Date Taken: / /
Indicate the specific tooth number(s) for crowns, dental implants, impacted teeth, bridges, and teeth extracted since images taken:

If request is for Periodontal Services, complete boxes # 16 - 17

16. Required current comprehensive periodontal charting attached? ☐ Yes ☐ No
Periodontal charting must include 6 measurements per tooth and all of the following applicable: probing depths ≥ 4mm, BOP and/or gingival inflammation, attachment loss, furcation, mobility.

Completion of boxes #16 – 17 satisfies requirement for inclusion of clinical record.

17. Periodontal diagnosis (Refer to American Academy of Periodontology (AAP) guidelines for periodontal diagnosis and classification).
Stage (I, II, III, IV): ☐ Localized ☐ Generalized ☐ Molar/incisor pattern
Grade (A, B, C):
Address the 1 year prognosis of teeth in each quadrant being requested:

18. Other Pertinent Dental or Medical History:

19. Additional Provider Comments:

LINE	20. **CDT PROCEDURE CODE**	21. **TOOTH NUMBER(S)**	22. **QUADRANT** (1 quadrant per line)	23. **DESCRIPTION OF SERVICE**
1				
2				
3				
4				
5				
6				
7				
8				

24. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law. Signature of a licensed dentist or dental therapist is required.

Provider's Name (typed/printed): Provider's Signature: Date:

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with aphakia who are under six years of age.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Anirida
- ☐ Anisometropia or Antimetropia
- ☐ Aphakia
- ☐ Irregular Corneas *
- ☐ Keratoconus * (If vision can not be improved to 20/40 or better with eyeglasses.)
- ☐ Other conditions with no alternative treatment (e.g., Aniseikonia (with documentation), Keratoconjunctivitis Sicca)

_____

_____

Diagnosis(es) Code: _____

Current spectacle correction:				**Best spectacle correction:**			
R	_____	**VA**	_____	**R**	_____	**VA**	_____
L	_____	**VA**	_____	**L**	_____	**VA**	_____
ADD	_____			**ADD**	_____		

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO
If yes, explain:

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO
If yes, indicate reason for new lenses:

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Mire Quality

R _____

L _____

*** A corneal topography for Keratoconus and Irregular Cornea diagnoses may be requested.**

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable or Hybrid

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Complete description of contact lens parameters		
Material of the contact lens		
Manufacturer of the contact lens		
Brand Name		
Manufacturer's wholesale cost		
Number of lenses required to provide one-year supply		
Prescription expiration date		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours):_____ _____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

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DCH-1401, ELECTRONIC SIGNATURE AGREEMENT

Michigan Department of Health and Human Services
(Revised 2-22)

SECTION 1

Employer or Employing Entity Name | Employer Identification Number | NPI

Individual Name (Doctor, Dentist, Nurse, etc.) | NPI

SECTION 2

The undersigned Individual and Employing Entity attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the Employing Entity has the authority to sign and submit the electronic Michigan Department of Health and Human Services Medical Assistance Provider Enrollment Trading Partner Agreement and to maintain enrollment information through the MDHHS CHAMPS Provider Enrollment Subsystem. Both parties also agree that the Employing Entity listed above is liable and bound by all information submitted on his or her behalf as if the Employing Entity had submitted changes to CHAMPS directly.

Individual Signature | Date

Employing Entity Signature | Date

Individual MILogin User ID | Date

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Michigan Department of Health and Human Services

Genetic and Molecular Laboratory Test Authorization Request - Completion Instructions

The MSA-2081 is used by Medicaid-enrolled medical practitioners and laboratory providers to request genetic and molecular laboratory testing services that require MDHHS approval. Authorization must be requested within 30 days of the specimen collection date. Specimen processing should not be completed until after the authorization has been approved.

Authorization requests will be reviewed for medical necessity based on the genetic and molecular testing standards of coverage available in the Laboratory chapter of the MDHHS Medicaid Provider Manual. Authorization requests require medical documentation from the beneficiary's Medicaid-enrolled treating provider. Medical necessity letters or test request forms created by the performing laboratory and signed by the treating provider will not be accepted as a substitute for clinical documentation or completion of the MSA-2081.

The completed MSA-2081 and/or clinical records from the treating provider must document the following:

- Indication for the test. This should be beneficiary-specific and medical in nature.
- Beneficiary's related signs and symptoms and/or family history relevant to the requested test.
- Other related testing or clinical findings of the beneficiary or family member relevant to the requested test.
- How the test results will be utilized to significantly alter the medical management or treatment of the disease.

For complete information on coverage, documentation, claims completion, and reimbursement, refer to the following documents:

- Laboratory Chapter of the MDHHS Medicaid Provider Manual.
- Billing & Reimbursement for Professionals chapter of the MDHHS Medicaid Provider Manual.
- Laboratory databases on the MDHHS website:
  www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

The MSA-2081 must be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 2	Enter the laboratory name.
Box 3	Enter the laboratory NPI number.
Box 19	Enter the date of service. This should be the date the specimen was collected.
Box 21	Enter a complete description of the laboratory test requested.
Box 22	Enter the HCPCS/CPT Procedure Code.
Box 26	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description) necessitating the requested test.
Box 29	The definitive treatment or action plan should be specific to the beneficiary.
Box 30	List other insurance coverage available for services requested and additional remarks pertinent to the request.
Box 31	Must be completed for all requests.

Form Submission

This form and required documentation must be submitted electronically utilizing the CHAMPS Prior Authorization Request List page. Providers unable to submit electronically may submit the form and documentation via fax or mail to:

MDHHS
Program Review Division
P.O. Box 30170, Lansing, Michigan 48909

Fax Number: (517) 335-0075

Providers may check the status of an authorization request on the CHAMPS Prior Authorization Request List page or by contacting the MDHHS, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

GENETIC AND MOLECULAR LABORATORY TEST AUTHORIZATION REQUEST

1. AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

This completed form and clinical records included with the form must document the following:

- Beneficiary-specific medical indication(s) for the requested test.
- Beneficiary's signs and symptoms, relevant family history, and other testing or clinical findings of the beneficiary or family member relevant to the requested test.
- How the test results will be utilized to significantly alter the medical management or treatment of the condition/disease.

2. LABORATORY NAME	3. NPI NUMBER	4. PHONE NUMBER ( ) -
5. LABORATORY ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER ( ) -

7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE / /	10. BENEFICIARY ID NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			

12. ORDERING PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	13. NPI NUMBER	14. ORDERING PROVIDER SPECIALTY/TAXONOMY
15. ORDERING PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		16. PHONE NUMBER ( ) -

17. FAX NUMBER ( ) -	18. CONTACT PERSON AND PHONE ( ) -	19. DATE OF SERVICE/SPECIMEN COLLECTION DATE / /

20. LINE NO.	21. TEST NAME	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE
01					
02					
03					
04					

26. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE REQUESTED TESTS:	27. DISEASE/CONDITION/GENE MUTATION BEING TESTED FOR:

BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL): BENEFICIARY ID NUMBER:

28. BENEFICIARY'S SYMPTOMS, CLINICAL FINDINGS, PREVIOUS TEST RESULTS, FAMILY HISTORY, AND/OR ETHNIC BACKGROUND THAT SUPPORTS THE NEED FOR THIS GENETIC TEST. ATTACH SUPPORTING CLINICAL DOCUMENTATION AS NEEDED:

29. WILL THE TEST RESULTS CHANGE THE BENEFICIARY'S TREATMENT (FREQUENCY, INTENSITY, OR TYPE OF SURVEILLANCE OF THE DISEASE/CONDITION) OR ESTABLISH A DIAGNOSIS? IF YES, DESCRIBE:

DIAGNOSIS: ☐ NO ☐ YES, DESCRIBE:

GUIDING SURVEILLANCE: ☐ NO ☐ YES, DESCRIBE:

MEDICAL INTERVENTION: ☐ NO ☐ YES, DESCRIBE:

MEDICATION MANAGEMENT: ☐ NO ☐ YES, DESCRIBE:

OTHER: ☐ NO ☐ YES, DESCRIBE:

30. OTHER RELEVANT INFORMATION RELATED TO THE TESTING BEING REQUESTED OR ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE:

31. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER OR LABORATORY REPRESENTATIVE'S PRINTED NAME AND SIGNATURE: DATE / /

MDHHS USE ONLY

32. REVIEW ACTION AND CONSULTANT REMARKS ☐ SEE CHAMPS

☐ APPROVED ☐ RETURN

☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED

CONSULTANT SIGNATURE DATE

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Michigan Department of Health and Human Services
Completion Instructions for MSA-181
Home Health Aide Prior Approval Request/Authorization

General Instructions

The MSA-181 must be used by Medicaid enrolled and home health agencies to request Prior Authorization (PA) for home health aide services. MDHHS requires that the MSA-181 be typewritten; handwritten forms will not be accepted. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for home health aide services for beneficiaries with Medicaid. A request to begin services may be submitted by a person other than the home health agency such as the hospital Discharge Planner or physician. When this is the case, the person submitting the request must do so in consultation with the beneficiary (parent or guardian if applicable), and home health agency who will be assuming responsibility for the care of the beneficiary.

PA may be authorized for a period not to exceed ninety days. If need for home health aide services are medically necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is returned.

Refer to the Medicaid Provider Manual, Home Health Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	The Home Health Agency Provider Name.
3	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
4-9	The Home Health Agency provider's telephone number (including area code), address and fax number (including area code).
10	**Initial:** The authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan.
11-19	Beneficiary information. Provide complete name, sex, mi health card number, date of birth, complete address (including city, state, and zip code), and phone number.
20-21	Enter the beneficiary's diagnosis(es) code(s) and and onset date that relate to the service being requested.
22	The beneficiary's most recent hospital discharge date for the requesting prior authorization period.
23-25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26	The start date of the last approved authorization period.
27	The previous total number of home health aide visits rendered (since services were first started).
28	The date home health services were first started.
29	For this current request being submitted, indicate requested start and end dates, total quantity of procedure code G0156 (i.e. visits) requested, and the planned visit frequency during the requested authorization period.
30	Indicate if the current authorization request is an increase or decrease from previous authorization, or if a change is being requested for the currently approved authorization period.
31	List the beneficiary's current medications relevant to the medical diagnosis.
32	Documentation of the beneficiary's cognitive status.
33	Identify the beneficiary's ability to complete range of motion for upper and lower extremities.

34	Evaluation includes OASIS coding of the beneficiary. **OASIS Coding** 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance** – Helper providers VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**
35	Indicate the service and frequency of the service for this authorization request.
36	Identify the medical need for additional services. Service request must be specific, include supportive documentation of the beneficiary's current level of function and the medical necessity of requested service(s).
37	List all other services in the home. Must include the frequency of the service(s) and payer(s). Failure to disclose all services in the home may result in recoupment of Medicaid dollars for home health aide reimbursement.
38	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. All unsigned requests will be returned for signature.
39	The physician, nurse practitioner, clinical nurse specialist, or physician assistant's signature certifies that (1) the Home Health agency requesting the services understands the medical necessity for obtaining prior authorization for Home Health services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
40	The licensed supervising professional's signature certifies that (1) the licensed, registered nurse, physical therapist, occupational therapist, or speech/language therapist provides supervision of the home health aide; (2) the services are medically necessary for obtaining prior authorization for Home Health aide services and; (3) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
41-42	MDHHS use only

RETURN COMPLETED FORM AND REQUIRED DOCUMENTATION TO:

MDHHS
Program Review Division
PO Box 30170
Lansing, MI 48909

OR

Fax to: 517-335-0075

Questions should be directed to MDHHS – Behavioral and Physical Health and Aging Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.	

HOME HEALTH AIDE
PRIOR APPROVAL REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

The provider is responsible for eligibility verification.
Approval does not guarantee beneficiary eligibility or payment.

1. Prior Authorization Number (MDHHS USE ONLY)

MDHHS requires this form to be typewritten; handwritten forms will not be accepted.

2. Home Health Agency Provider Name	3. Provider NPI Number	4. Provider Phone Number	5. Provider Fax Number

6. Home Health Agency Provider Address (Number, Street, Building, Suite Number, etc.)	7. City	8. State	9. Zip Code

10. Home Health Aide Authorization Request ☐ Initial ☐ Continuing

11. Beneficiary Name (Last, First, Middle Initial)	12. Beneficiary Date of Birth	13. Sex	14. mihealth ID Number	15. Beneficiary Telephone Number
		☐ M ☐ F		- -

16. Beneficiary Address (Number, Street, Apt/Lot, etc.)	17. City	18. State	19. ZIP Code

20. Medical ICD Diagnosis(es) Code(s) Requiring Home Health Services	21. Onset Date	22. Most Recent Hospital Discharge Date

23. Primary Caregiver(s)	24. Relationship(s) to Beneficiary	25. Primary Caregiver(s) Phone Number(s)
		- -
		- -

26. Date of Last Authorization	27. Number of Previous Visits	28. Date Home Health Aide Service(s) Started	29. Current Request Requested Start Date: Requested End Date: Requested Qty Code G0156: Visit Frequency:	30. Number of Visits Requested compared to Last Authorization ☐ Increase ☐ Decrease ☐ Change to current authorization

Beneficiary's Current Functional Level and Services

31. List Current Medications:

32. Cognitive: ☐ Alert/oriented ☐ Able to Direct Care ☐ Impaired/Developmental Delay ☐ Disoriented ☐ Unresponsive

33. Range of Motion Exercises: Upper Extremity: ☐ Independent ☐ Requires Assistance / Dependent

Lower Extremity: ☐ Independent ☐ Requires Assistance / Dependent

34. SCORE: (see instructions)	06	05	04	03	02	01	07	09	88	35. Services & frequency to be performed by aide
Bathing/Skin Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oral Hygiene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transfers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Positioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medication Management, if applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vital Signs										☐

36. Other Services (Must specify service(s) include documentation of current level of function and medical necessity for each)

Beneficiary Name: _____ mihealth ID Number: _____

37. Other Services Currently Received By Beneficiary (Check All)				Frequency	Payer
Skilled Nursing Visits	☐ No	☐ Yes			
Private Duty Nursing	☐ No	☐ Yes			
Physical Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Occupational Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Speech Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Home Help	☐ No	☐ Yes			
Community Living Services (CLS)	☐ No	☐ Yes			
Other Behavioral Health Services	☐ No	☐ Yes	Specify:		
Waiver Services	☐ No	☐ Yes	Specify:		
Hospice	☐ No	☐ Yes			
Other Services	☐ No	☐ Yes	Specify:		

☐ Home Health Agency Plan of Care Attached (Most Recent Plan Of Care Must Accompany Request)

☐ Copy of Oasis Must Be Attached With Initial Request And Annually Thereafter

38. PATIENT (PARENT / GUARDIAN IF APPLICABLE) CERTIFICATION	39. PRACTITIONER CERTIFICATION	40. LICENSED SUPERVISING PROFESSIONAL CERTIFICATION
I, the patient (parent/guardian) named above, understand the necessity to request prior authorization for the medically necessary services indicated. I understand that services requested herein require prior authorization and, if approved and submitted by the agency on the appropriate invoice, payment of authorized services will be from general and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I certify that I have examined the patient named above and have determined that home health aide services are medically necessary, as supervised by a licensed, registered nurse or other authorized licensed professional. I understand that home health aide services require prior authorization to validate that such services are deemed medically necessary in accordance with Michigan Medicaid Provider Manual policy. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I hereby attest as a licensed professional (registered nurse, physical therapist, occupational therapist, or speech/language pathologist) that supervision of the home health aide is under my authority and deemed medically necessary. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.
PATIENT NAME (PARENT / GUARDIAN) _____ PRINTED _____ SIGNATURE DATE	PRACTITIONER NAME _____ PRINTED _____ SIGNATURE DATE	SUPERVISING PROFESSIONAL NAME _____ PRINTED _____ SIGNATURE DATE

MDHHS USE ONLY

41. REVIEW ACTION:	42. CONSULTANT REMARKS AND AUTHORIZATION PERIOD IF APPROVED:
☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED	☐ See CHAMPS ☐ KEEP IN FILE ☐ KEEP IN FILE ☐ KEEP IN FILE CONSULTANT SIGNATURE / DATE

Michigan Department of Health and Human Services

HOME HELP AGENCY CAREGIVER ENROLLMENT AUTHORIZATION

This form must be used to document an agency caregiver's consent to be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). The form is needed only when the agency caregiver will be absent during the submission of their CHAMPS enrollment application.

To protect client safety, the agency caregiver must not provide Home Help services until their CHAMPS enrollment application has been approved and the agency caregiver has associated to the agency provider in CHAMPS. A failure to comply with these requirements may result in recoupment of payments for services the agency caregiver provides.

COMPLETION INSTRUCTIONS:

The agency caregiver has the sole authority to submit their CHAMPS enrollment application. If they choose to delegate that authority to the agency provider, the following steps are required:

1. **The agency provider completes Section 1 of the form.**

2. **The agency caregiver completes Sections 2 through 5 of the form and returns it to the agency provider.** The agency caregiver's signatures in Sections 3 and 5 must be handwritten. The agency provider must not enroll the agency caregiver in CHAMPS before this step is completed.

3. **The agency provider creates a unique MILogin user ID and password for the agency caregiver and enters the agency caregiver's responses from Section 4 of the form into CHAMPS.** The agency provider must not use the MILogin user ID and password for any purpose other than to enroll the agency caregiver.

4. **The agency provider enters the agency caregiver's MILogin user ID and password and CHAMPS provider ID into Section 6 of the form and gives a copy of the completed form to the agency caregiver.** The form should be returned promptly to the agency caregiver to ensure they have the information needed to manage their MILogin account and CHAMPS enrollment. If the agency caregiver's CHAMPS enrollment is not approved, the agency provider should still provide the agency caregiver with their MILogin user ID and password.

5. **The agency provider retains the signed form in a secure environment for seven years after the agency caregiver's last date of service.** The form should only be submitted to MDHHS if requested by MDHHS staff. Failure to retain or provide MDHHS with the form during an investigation or audit may result in recoupment.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY:	Title XIX of the Social Security Act and Administrative Rule 400.1104(a)
COMPLETION:	Is voluntary, but is required if Medical Assistance program payment is desired.

HOME HELP AGENCY CAREGIVER ENROLLMENT AUTHORIZATION

Michigan Department of Health and Human Services

SECTION 1 – AGENCY PROVIDER INFORMATION

Agency Name	Provider ID Number

SECTION 2 – AGENCY CAREGIVER INFORMATION

Name (First, Last)	Address (Number and Street, Apartment/Lot Number)		
City	State	Zip Code	Date of Birth

Home Telephone Area Code and Number	Cell Phone Area Code and Number
Social Security Number	Email Address

SECTION 3 – CONSENT TO BE ENROLLED IN CHAMPS

Home Help is a Medicaid-funded program. Only Medicaid-approved providers may work with Home Help clients. MDHHS uses CHAMPS to enroll and approve Medicaid providers. **You must be enrolled in CHAMPS as a Medicaid-approved provider before you work with Home Help clients.**

You will enter CHAMPS through the MILogin website. With MILogin, you only need one user ID and password to enter many State of Michigan websites.

You have chosen to have the agency provider in Section 1 of this form create your MILogin user ID and enroll you in CHAMPS. The agency provider may use your MILogin user ID to check on your CHAMPS enrollment application. The agency provider will give you your MILogin user ID. If your CHAMPS enrollment application is approved, the agency provider will also give you your CHAMPS Provider ID.

You will own your MILogin account and CHAMPS enrollment. As the owner, you will be responsible for any actions taken with your MILogin account and CHAMPS enrollment. You must not share your MILogin user ID and password and your CHAMPS Provider ID.

You should protect your MILogin account and CHAMPS enrollment by changing your MILogin password. If you need help changing your password, call Provider Support at 1-800-979-4662.

By signing below, I agree to have the agency provider create my MILogin user ID and enroll me in CHAMPS. I know the agency provider may need to use my MILogin user ID to check on my CHAMPS enrollment application. I know I am responsible for actions taken with my MILogin account and CHAMPS enrollment. Once I receive my MILogin user ID and password and my CHAMPS Provider ID, I agree not to share them. I know I am responsible for protecting this information by changing my MILogin password.

Agency Caregiver Signature	Date Signed

SECTION 4 – FINAL ADVERSE LEGAL ACTIONS/CONVICTIONS

1. Have you ever been convicted of a felony or misdemeanor crime? If yes, please explain.	☐ Yes ☐ No
2. Have you ever been removed from or told you cannot participate in a state or federally funded program? If yes, please tell us what program and why.	☐ Yes ☐ No

SECTION 5 – HOME HELP PROGRAM TERMS AND CONDITIONS

By signing below, I agree that I have read the following statements and agree to follow all federal, state and MDHHS rules.

1. I know I work for the agency provider. I am not employed by MDHHS or the State of Michigan.
2. I know MDHHS will use my CHAMPS enrollment to run criminal history screenings. The results of these screenings may prevent me from working as a Medicaid-approved provider. The results will be shared when needed with MDHHS staff, agency provider staff and Home Help clients.
3. I agree to keep my CHAMPS enrollment current. I will update my CHAMPS enrollment within 10 days of any change in my information. This includes but is not limited to a change in my address, phone number or email.
4. I agree to provide the services to the Home Help client that the agency provider assigns to me. I know the hours of services I provide to the Home Help client may not go over the total approved hours listed on the Home Help client's Time and Task.
5. I know I can only receive wages from the agency provider for the services I provide. I will not seek or accept payments from the Home Help client or any other source.

6. I agree to give the agency provider all records needed to show the services I provided to Home Help clients. I know that listing services I did not provide is fraud and could result in criminal charges.
7. I agree to cooperate with MDHHS and/or the agency provider on any audits, investigations or requests for information about Home Help services provided.
8. I know I must tell the agency provider if I am arrested or convicted of a crime.
9. I agree to let the agency provider know of any changes with the Home Help client. This includes but is not limited to the Home Help client being admitted to a hospital, staying in a nursing home or ending Home Help services.
10. I agree to follow the laws on the use and sharing of the Home Help client's protected health information (PHI). This includes the privacy rules in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Public Acts 104-191 (45 CFR Parts 106 and 164, Subparts A, C, and E).
11. I agree to follow the rules for Medicaid providers in 42 CFR 431.107, Act No. 280 of the Public Acts of 1939 and the MDHHS Medicaid Provider Manual.

Agency Caregiver Signature Date Signed

SECTION 6 – AGENCY CAREGIVER MILOGIN USER ID / PASSWORD AND CHAMPS PROVIDER ID

MILogin User ID	MILogin Password	CHAMPS Provider ID

Michigan Department of Health and Human Services

HOME HELP AGENCY INVOICE

Instructions for Completing the Home Help Agency Invoice

NOTE: Total time billed must not exceed the agency provider's approved Time and Task amount. Authorized payments will not include billed time in excess of the approved amount.

1. The agency provider completes the following sections of the Home Help Agency Invoice to document the provision of personal care services for each day in the month and year indicated.

A. BILLING INFORMATION

1. **AGENCY NAME:** Enter the complete name of the agency provider.
2. **AGENCY PROVIDER NUMBER:** Enter the CHAMPS ID number of the agency provider.
3. **AGENCY PHONE NUMBER:** Enter the phone number where the agency representative can be reached.
4. **CONTACT PERSON:** Enter the first and last name of the agency representative.
5. **BILLING PERIOD:** Enter the Billing Month and Year (MM/YYYY).
6. **DATE SUBMITTED:** Enter the date the invoice is submitted to the client's local county MDHHS office (MM/DD/YYYY).
7. **HOURLY RATE:** Enter the agency provider's MDHHS-approved hourly rate for the client.
8. **CLIENT NAME:** Enter the first and last name of the client.
9. **CLIENT MEDICAID ID NUMBER:** Enter the client's Medicaid Identification Number.
10. **BILL TO:** Enter the name of the client's local county MDHHS office.
11. **ATTENTION:** Enter the name of the client's adult services worker.

B. VERIFICATION OF SERVICES AND HOSPITAL/NURSING FACILITY STAYS

1. For each day of the billing month, check all the approved tasks completed.
2. If the client stayed in a hospital or nursing facility, check the day(s) the client was admitted, the day(s) the client stayed in the facility and the day(s) the client was discharged.
3. When Laundry is checked and was completed at a laundry facility, check Travel Time for Laundry. When Shopping is checked and required travel to one or more stores, check Travel Time for Shopping. **NOTE**: The frequency of travel must not exceed the agency provider's approved Time and Task amount.
4. Enter total hours and minutes of service provision in the Total Time for Services Above field.

C. VERIFICATION OF COMPLEX CARE TASKS: For each day of the billing month, check all the approved tasks completed. Enter total hours and minutes of service provision in the Total Time for Services Above field. **NOTE**: Complete only if complex care tasks were provided.

D. TOTAL TIME FOR BILLING PERIOD: Add together the times in the Total Time for Services Above and the Total Time from the Previous Page fields. Record the total time in hours and minutes. **NOTE**: Complete only if complex care tasks were provided.

E. SIGNATURE OF AUTHORIZED REPRESENTATIVE / DATE: Sign and date the invoice to certify provision of the approved tasks. **NOTE:** If complex care tasks were provided, sign and date both pages of the invoice.

2. The agency provider sends the completed Home Help Agency Invoice to the client's local county MDHHS office – Attention: Adult Services Unit. The invoice should not be submitted before the last day of the services billing period. The invoice must be submitted to the Adult Services Unit of the client's local county MDHHS office **no later than** 365 days from the service date. **Failure to submit the invoice within 365 days of the service date will result in non-payment.**

APPROVED PERSONAL CARE TASKS

NOTE: Approved time for items 1 through 13 is for hands-on care only.

1. **Eating/Feeding –** helping with use of utensils, cup/glass, getting food/drink to mouth, cutting up/manipulating food on plate, cleaning face and hands, as needed after a meal.
2. **Toileting –** helping on/off toilet, commode/bed pan, emptying commode/bed pan, managing clothing, wiping and cleaning body after toileting, cleaning ostomy and/or catheter tubes/receptacles, applying diapers and disposable pads; may include doing catheter, ostomy or bowel programs.
3. **Bathing –** helping with cleaning the body or parts of the body, shampooing hair, using tub or shower, sponge bathing, including getting a basin of water, managing faucets, soaping, rinsing and drying.
4. **Grooming –** helping to maintain personal hygiene and neat appearance, including hair combing, brushing, oral hygiene, shaving, fingernail and toe nail care (unless a physician advises not to do so).
5. **Dressing –** helping with putting on/taking off, fastening/unfastening garments/undergarments, special devices such as back/leg braces, corsets, artificial limbs or splints.
6. **Transferring –** helping to move from one position to another, such as from a bed to a wheelchair or sofa, to come to a standing position and/or repositioning to prevent skin breakdown.
7. **Mobility –** helping with walking or moving around inside the living area, changing locations in a room, moving from room to room or climbing stairs.
8. **Medication –** helping with administering prescribed or over-the-counter medication.
9. **Meal Preparation –** helping with planning menus, washing, peeling, slicing, opening packages, cans and bags, mixing ingredients, lifting pots/pans, reheating food, cooking, operating stove/microwave, setting the table, serving the meal, washing/drying dishes and putting them away.
10. **Shopping –** helping to compile a list identifying needed items, picking up items at the store, managing cart/baskets, transferring items to home and storing them away.
11. **Laundry –** helping by getting laundry to machines, sorting, handling soap containers, placing laundry into machines, operating machine controls, handling wet laundry, drying, folding and storing laundry.
12. **Light Housework –** helping with sweeping, vacuuming, washing floors, washing kitchen counters and sinks, cleaning the bathroom, changing bed linen, taking out trash, dusting and picking up, bringing in fuel for heating/cooking purposes if necessary.
13. **Complex Care tasks –** require special techniques/knowledge; may replace most or all 1-9 tasks when approved by specialist. Complex care tasks include bowel program, catheter or leg bags, colostomy care, eating or feeding assistance, peritoneal dialysis, range of motion exercises, specialized skin care, suctioning and wound care.

INSTRUCTIONS FOR ADULT SERVICES WORKER

1. When the invoice is returned, review for accuracy. If invoice is correct, authorize payment.
2. Resolve inaccuracies immediately. Once invoice is corrected, authorize payment.
3. Maintain the invoice in the client's case record.

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AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a)
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

HOME HELP AGENCY INVOICE

Michigan Department of Health and Human Services

Agency Name	Agency Provider Number	Agency Phone Number

Contact Person	Billing Period <Enter mm/yyyy>	Date Submitted	Hourly Rate

Client Name:	Client Medicaid ID Number:

Bill To:	<Enter client's local county MDHHS office>	Attention: <Enter client's adult services worker>

VERIFICATION OF SERVICES AND HOSPITAL/NURSING FACILITY STAYS

Days of Billing Month	Bathing	Dressing	Eating	Grooming	Mobility	Toileting	Transferring	Housework	Laundry	Travel Time for Laundry	Medication	Meal Preparation	Shopping	Travel Time for Shopping	Hospital/Nursing Facility Stay
1	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Total Time for Services Above: <Enter hh:mm>

I certify that has provided all the services as checked above.

<Enter Signature of Authorized Representative> <Enter Date>

Signature of Authorized Representative	Date

Client Name	Adult Services Worker Name	Billing Period
	<Enter client's adult services worker>	<Enter mm/yyyy>

HOME HELP AGENCY INVOICE

Michigan Department of Health and Human Services

VERIFICATION OF COMPLEX CARE TASKS

Days of Billing Month	Bowel Program	Catheters for Leg Bags	Colostomy Care	Eating or Feeding Assistance	Peritoneal Dialysis	Range of Motion Exercises	Specialized Skin Care	Suctioning	Wound Care
1	☐	☐	☐	☐	☐	☐	☐	☐	☐
2	☐	☐	☐	☐	☐	☐	☐	☐	☐
3	☐	☐	☐	☐	☐	☐	☐	☐	☐
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5	☐	☐	☐	☐	☐	☐	☐	☐	☐
6	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Total Time for Services Above: <Enter hh:mm>
Total Time from Previous Page: <Enter hh:mm>
Total Time for Billing Period: <Enter hh:mm>
I certify that ___ has provided all the services as checked above.
<Enter Signature of Authorized Representative> <Enter Date>

Signature of Authorized Representative | Date

HOME HELP AGENCY PROVIDER EMPLOYMENT REQUIREMENTS

Michigan Department of Health and Human Services

The purpose of this form is to help agency applicants understand and comply with Home Help employment policies. The form contains a subset of the policies that an approved agency provider must follow. For a full list of Home Help policies, see the Home Help chapter in the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual.

Instructions for Completing this Form

SECTION 1: Enter the agency's full legal name and Employer Identification Number and the first and last name of the person completing the form. The form must be completed by an agency owner or managing employee. For definitions of these terms, see the Common Terms Section of the Home Help chapter in the MDHHS Medicaid Provider Manual.

SECTION 2: Review the policies and sign and date this section to affirm the agency's understanding of and agreement to comply with the policies. The signature must be handwritten. If the agency has questions about the policies, contact the MDHHS Home Help Policy Section at mdhhs-hhnewagencyproviderapplications@michigan.gov.

SECTION 3: Complete this section only if the agency currently employs at least two directly hired agency caregivers other than the agency owner who will provide Home Help services. All the agency's directly hired agency caregivers should be listed. Do not include the agency owner(s). If additional space is needed, submit a separate document listing the additional agency caregiver names and provider ID numbers (if available). ***If the agency does not employ a minimum of two directly hired agency caregivers, skip to Section 4*.**

SECTION 4: ***Complete this section only if the agency is unable to complete Section 3***. In the space provided, briefly summarize the agency's plan for recruiting and directly hiring at least two agency caregivers other than the agency owner.

SUBMISSION INSTRUCTIONS: The completed form should be emailed with agency application documents to mdhhs-hhnewagencyproviderapplications@michigan.gov.

DOCUMENT RETENTION REQUIREMENTS: Retain a copy of the completed form in a secure location for seven years after the signature date in Section 2 of the form.

HOME HELP AGENCY PROVIDER EMPLOYMENT REQUIREMENTS
Michigan Department of Health and Human Services

SECTION 1 – AGENCY APPLICANT INFORMATION

Agency Name	Employer Identification Number
Name of Agency Owner or Managing Employee Completing the Form	

SECTION 2 – ACKNOWLEDGEMENT OF AGENCY PROVIDER EMPLOYMENT POLICIES

By signing below, I affirm I understand and agree to ensure full agency compliance with the following agency provider employment policies:

- Agency caregivers who provide Home Help services must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) as atypical individual providers and associated to the agency prior to providing Home Help services. The date of association must not be earlier than the date the criminal history check was completed.
- An agency caregiver who provides Home Help services must be present during the submission of their CHAMPS enrollment application or complete the MSA-204 Home Help Agency Caregiver Enrollment Authorization form prior to the agency provider enrolling them in CHAMPS.
- Agency employees who have access to client information for the purposes of billing, answering phone calls, or assisting with setting up services for the client must be listed in the agency provider's CHAMPS enrollment in "Step 9: Provider Controlling Interest/Ownership Details" prior to accessing the information.
- The agency provider must directly employ all agency caregivers and agency employees who work with Home Help clients. Agency caregivers and agency employees may not subcontract services to persons who are not directly employed by the agency provider. Medicaid will not reimburse an agency provider for services that were provided by a contracted agency caregiver.
- The agency provider must directly employ a minimum of two agency caregivers, not including the owner, who provide services through the Home Help program and regularly receive a monthly paycheck.
- The agency owner(s) must ensure all agency caregivers and agency employees who work with Home Help clients know and comply with Home Help policy.
- When MDHHS determines it paid for services provided by one or more agency caregivers and/or agency employees who were not in compliance with Home Help policy, MDHHS will recoup the overpayments from the agency provider.

Agency Owner or Managing Employee Signature	Date Signed

SECTION 3 – CURRENT AGENCY CAREGIVERS

Complete this section only if the agency currently employs at least two directly hired agency caregivers **other than the agency owner** who will provide Home Help services. If the agency does not meet this staffing level, skip to Section 4. See the instructions page for more guidance on completing this section.

Names of Directly Hired Agency Caregivers	Provider ID Numbers (If available)

SECTION 4 – AGENCY CAREGIVER RECRUITMENT PLAN

Complete this section only if the agency is unable to list directly hired agency caregivers in Section 3 of this form. See the instructions page for more guidance on completing this section.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act and Administrative Rule 400.1104(a)
COMPLETION: Is voluntary, but is required if Medical Assistance program payment is desired.

Michigan Department of Health and Human Services

HOME HELP BILLING FOR HOSPITAL ADMISSION DATE

A Home Help provider may be paid for services on the day the Home Help client was admitted to a hospital if:

- The services were provided on or after February 1, 2023.
- The services were provided before the time the Home Help client was admitted to the hospital.
- The services were provided in the Home Help client's home or workplace. **NOTE**: Laundry and shopping authorized to be done outside the Home Help client's home may be eligible for payment if completed before the time the Home Help client was admitted to the hospital.
- The Home Help client has active Medicaid.
- The provider logs the tasks they provided on the service verification. Individual caregivers must log the tasks on the Electronic Service Verification (ESV) or Paper Service Verification (PSV). Agency providers must log the tasks on the MSA-1904 Home Help Agency Invoice.
- The provider fills out, signs and dates this form and sends it to the Home Help client's adult services worker or local MDHHS office within 365 days of the date of service.

How to Complete and Submit this Form

SECTION 1: Fill in the Home Help client's first and last name. Fill in the Home Help client's Medicaid identification (ID) number if available.

SECTION 2: Fill in the Home Help provider's information. An individual caregiver fills in their first and last name and provider ID number. A Home Help agency provider fills in:

- The name of the agency.
- The agency's provider ID number.
- The first and last name of the agency caregiver who provided services to the Home Help client on the hospital admission date.
- The agency caregiver's provider ID number.

SECTION 3: Fill in the date and time the services were provided, including:

- The date the Home Help client was admitted to the hospital.
- The time Home Help services began and the time Home Help services ended. Times must be recorded in an hh:mm format. "AM" or "PM" must be checked.

SECTION 4: This section must only be signed by an individual caregiver employed by the Home Help client or an authorized Home Help agency representative. An authorized Home Help agency representative is a person who is authorized to act on behalf of the agency owner. The signature must be handwritten.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY:	Title XIX of the Social Security Act and Administrative rule 400.1104(a)
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.

HOME HELP BILLING FOR HOSPITAL ADMISSION DATE

Michigan Department of Health and Human Services

Case Log Number
Local MDHHS Office
Adult Services Worker Name
Adult Services Worker Email Address

SECTION 1 – Home Help Client Information

Home Help Client Name	Medicaid ID Number

SECTION 2 - Home Help Provider Information

Individual Caregiver or Agency Provider Name	Provider ID Number
For Agency Providers Only:	
Name of Agency Caregiver Who Provided Services	Provider ID Number

SECTION 3 – Date and Time Home Help Services Were Provided

Date of Hospital Admission	Time Home Help Services Began			Time Home Help Services Ended		
	hh:mm	AM ☐	PM ☐	hh:mm	AM ☐	PM ☐
NOTE: TO BE ELIGIBLE FOR PAYMENT, THE SERVICES PROVIDED ON THIS DATE MUST BE LOGGED ON THE HOME HELP PROVIDER'S SERVICE VERIFICATION.						

SECTION 4 – Attestation

By signing below, I affirm that:

- The information above and on the service verification is correct and true. The provider listed in Section 2 of this form provided the services before the time the Home Help client was admitted to the hospital.
- I know that billing for services that were not provided is fraud. I know it could result in provider termination or suspension from Medicaid programs; recoupment of the funds paid for the services; and criminal conviction. A criminal conviction could result in a fine up to $50,000 and a prison sentence of four to ten years for each count.
- I know that all information contained in this form is confidential and remains the property of MDHHS. I agree to maintain the confidentiality of any information provided to me by MDHHS and will follow all applicable state or federal laws concerning the confidentiality of the information therein. I will use appropriate safeguards to prevent unauthorized use or disclosure of the information contained in this form. If there is an unauthorized disclosure of the confidential information contained in this form or if this form is lost or stolen, I will contact the appropriate MDHHS staff member for further assistance within 24 hours of the unauthorized disclosure, lost, or theft becoming known to me.

Individual Caregiver or Authorized Agency Representative Signature	Date Signed

Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

INSTRUCTIONS

The MSA-2565-C serves as notice of birth of a newborn for the purposes of obtaining a Medicaid ID number. It must be completed only if the hospital is unable to submit notice of the birth through the Michigan Electronic Birth Certificate system.

- The hospital must retain **THE ORIGINAL** of the Hospital Newborn Notice in the beneficiary's file. A copy **MUST** be sent to the local MDHHS office.
- A copy of the MSA-2565-C will be returned to the hospital, noting the eligibility status of the newborn.
- Item 6 must state the name of the mother.
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the county, district, unit, worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

COMPLETION: Is voluntary

Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

1. Newborn Name *(Last, First, Middle)*	2. Newborn Gender ☐ M ☐ F	3. Newborn Birth Date / /	4. Newborn Social Security No. *(If Available)* – –
5. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
6. Name of Newborn's Mother *(Last, First, Middle)*	7. Phone No. ( ) –		
8. Mother Social Security No. *(If Available)* – –	9. Mother Birth Date / /		
10. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
11. Name of Provider	12. National Provider ID Number		
13. Provider Address *(No. & Street)*	City	State	Zip Code
14. Attending Physician Name	15. Hospital Case No. *(If Applicable)*		

16. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

17. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available

☐ Private Health Insurance (Complete items 18 thru 23 below)

18. Name of Policyholder (Private Health Ins.)	19. Policyholder's SS No. – –
20. Name of Insurance Company	
21. Location (City) / State	Zip Code
22. Group / Policy Number	23 Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section 11 above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

24. Signature of Patient's Representative / Date Signed / /	25. Signature of Person Completing This Form / Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient Representative for Explanation) ☐ **APPROVED** (see the Billing Information below)

Eligible Person's Name / Program		Grantee Name				
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.				MDHHS Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				

LIVE-IN CAREGIVER ATTESTATION

Michigan Department of Health and Human Services

Live-in caregivers employed by beneficiaries or agency providers are exempt from using Electronic Visit Verification (EVV). Exemptions must be approved by MDHHS or an Approving Entity. An “Approving Entity” is designated by MDHHS but is not an agency provider. The following criteria must be met for the caregiver to qualify for the EVV live-in caregiver exemption:

- The caregiver must live in the same home as the beneficiary; and
- The home must be the caregiver’s permanent and primary residence.

Live-in caregivers who do not meet the above criteria must use EVV to document personal care services.

INSTRUCTIONS

1. Use **two** of the following proofs of residency to verify the caregiver and beneficiary live at the same permanent, primary residence. Documents must include the live-in caregiver’s name and current home address. Electronic copies are acceptable. For annual renewals if the caregiver and beneficiary reside in the same address, these proofs of residency are not required.

   - Valid Michigan driver’s license
   - Valid Michigan state identification
   - Utility bill or credit card bill issued within the last 90 days
   - Account statement from a bank or other financial institution issued within the last 90 days
   - Mortgage, lease or rental agreement (Lease and rental agreements must include the landlord’s telephone number)
   - Pay stub or earnings statement issued within the last 90 days
   - Life, health, auto or home insurance policy
   - Michigan title and registration
   - Federal, state or local government documents, such as receipts, licenses or assessments

2. Complete this form using the following instructions.

   SECTION 1: Fill in the caregiver’s first and last name, email address, phone number, CHAMPS Provider ID Number, if applicable, and home address. The address must be the caregiver’s current, primary and permanent address.

   SECTION 2: Fill in the beneficiary’s first and last name, Medicaid ID number and home address. Check the box of the program of which the beneficiary is enrolled in and receives services. The address must be the beneficiary’s current, primary and permanent address.

   SECTION 3: The caregiver must provide a handwritten signature and the date of signature. The MDHHS or Approving Entity representative must review the form and attached documentation, sign and date the attestation form and check "Approved" or "Denied" with a reason for denial, if applicable.

HOW TO SUBMIT THIS FORM: Complete this form and submit it along with the documents to your program’s Approving Entity or MDHHS representative. This form can be submitted in person, by email, mail, or fax. Contact your beneficiary's adult services worker, supports/care coordinator, or case manager for assistance turning this form in.

HOW TO RETAIN THIS FORM: Keep a copy of the completed form in a secure place for seven years after the approved signature date in Section 3 of the form. The MDHHS or Approving Entity representative must comply with the privacy, security, and confidentiality provisions of all applicable laws governing the use and disclosure of protected health information (PHI).

LIVE-IN CAREGIVER ATTESTATION

Michigan Department of Health and Human Services

*This Attestation must be completed annually to renew live-in caregiver status

SECTION 1 – CAREGIVER INFORMATION

Purpose of Attestation (Check One): ☐ Initial Request ☐ Address Change ☐ Renewal			
First Name	Last Name		
Street Address	City	State	Zip Code
Email Address	Phone Number	CHAMPS Provider ID Number	

SECTION 2 – BENEFICIARY INFORMATION

First Name	Last Name	Medicaid ID Number	
Street Address	City	State	Zip Code
(Check One): ☐ Behavioral Health ☐ Home Help ☐ MI Choice ☐ MI Health Link			

SECTION 3 – ATTESTATION

I attest that I live with and provide personal care services to the beneficiary named above. I have provided the required proofs of address and agree to provide updated attestation every year or upon request to maintain live-in caregiver status and be exempt from Electronic Visit Verification (EVV) requirements. I also agree to notify MDHHS, the approving entity, fiscal intermediary or home care agency within 10 calendar days if my living arrangement changes and I no longer live with the beneficiary named above. I understand that failure to provide necessary updated documentation will result in me being required to use EVV.

Live-In Caregiver Signature	Date Signed

FOR MDHHS OR APPROVING ENTITY USE ONLY

I attest that the caregiver documented above provided at least two proofs of residency listed on the instructions page of this form or is renewing their attestation at the same address as previously recorded and approved. Based on my review of the documents provided, the caregiver is:

☐ Approved for the EVV live-in caregiver exemption.

☐ Denied Reason for Denial:

Name of Organization/Program of Approving Entity	

MDHHS or Approving Entity Staff Printed Name	
MDHHS or Approving Entity Staff Signature	Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act and Administrative Rule 400.1104(a)
COMPLETION: Is voluntary but is required if Medical Assistance program payment is desired.

Michigan Department of Health and Human Services

MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

Instructions for MSA-1755

The Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation form (MSA-1755) is to be completed by all Medicaid enrolled birthing hospitals in the State of Michigan.

The purpose of this form is to serve as an attestation that each Medicaid enrolled birthing hospital utilizes evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

To complete the form, hospitals must indicate whether they have elective delivery EBGs in place. If the hospital utilizes guidelines that are not listed on the form, hospitals may use the space provided on the form to explain. Hospitals may also submit copies of their elective delivery policies.

The form must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

The completed MSA-1755 must be mailed or emailed to:

Attn: Inpatient Hospital Policy
Michigan Department of Health and Human Services
Behavioral and Physical Health and Aging Services Administration, Program Policy Division
PO Box 30479
Lansing, Michigan 48909-7979
ProviderSupport@michigan.gov

Questions should be directed to Provider Support at ProviderSupport@michigan.gov.

AUTHORITY:	Title XIX of the Social Security Act	Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
COMPLETION:	Is Required.	

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race or national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Michigan Department of Health and Human Services

MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

The purpose of this agreement is to certify that Medicaid enrolled birthing hospitals utilize evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

NOTE: This agreement must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

Complete the following:

Hospital Name _____ **National Provider Identifier** _____

attests that the following elective delivery EBGs are utilized:

Yes	No	(Indicate Yes or No for each statement)
☐	☐	Medical indications for elective, non-medically indicated delivery prior to 39 weeks completed gestation are defined in hospital policy.
☐	☐	Hospital staff is not authorized to schedule an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Providers are required to obtain permission from physician leadership (e.g., the head of the obstetrics department) before performing an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Provider education materials are used to educate providers on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Patient education materials are used to educate patients on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Hospital involvement in an initiative that addresses elective, non-medically indicated delivery prior to 39 weeks completed gestation (e.g., Michigan Health & Hospital Association [MHA] Keystone Center's initiative in obstetrics, Trinity Health System's Perinatal Patient Safety Initiative [PPSI], Ascension Health System's Handling All Neonatal Deliveries Safely [HANDS]).
☐	☐	Other. Explain in the space provided below. If more space is needed, attach explanation on a separate document.

Along with this completed agreement, MDHHS will also accept a copy of each facility's elective delivery policy.

I certify that the responses in this attestation agreement are accurate, complete and current as of the date signed.

Signature of Chief Executive Officer	**Signature of Chief Medical Officer**
PRINT Name of CEO	PRINT Name of CMO
Telephone Number / Date	Telephone Number / Date

Michigan Department of Health and Human Services
Children's Special Health Care Services

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and\or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDHHS website at www.michigan.gov/mdhhs. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone **UNDER 21** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- Attach supporting medical documentation.
- If desired, make a photocopy for your records.
- **FAX** the completed form to **the CSHCS Division at 517-335-9491.**

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family MUST APPLY to join the CSHCS program by completing form **MSA-0737**, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES.
- If the family does NOT receive an application after notification of approval, call **1-800-359-3722**.

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)			Date of Birth	Sex ☐ **MALE** ☐ **FEMALE**
CLIENT'S Address (Number, Apt. No., Lot No.)			Social Security Number	HOME Phone Number ( ) –
City	State	ZIP Code	County	WORK Phone Number ( ) –
Does client have other health insurance? ☐ **NO** ☐ **YES** (Co. Name):			Is client enrolled in Medicaid? ☐ **NO** ☐ **YES** (Medicaid ID No.):	

Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.)
☐ Alaska Native ☐ American Indian ☐ Arabic ☐ Asian ☐ African American/Black ☐ Hispanic or Latino
☐ Caucasian/White ☐ Multi-racial/Ethnic ☐ Native Hawaiian/Other Pacific Islander ☐ Other:

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate boxes and complete information.)

☐ FATHER or ☐ LEGALLY RESPONSIBLE PARTY Name			☐ MOTHER or ☐ LEGALLY RESPONSIBLE PARTY Name		
Street Address (if different from client's)			Street Address (if different from client's)		
City	State	ZIP Code	City	State	ZIP Code
Social Security Number	Relationship to Client		Social Security Number	Relationship to Client	
HOME Phone Number ( ) –	WORK Phone Number ( ) –		HOME Phone Number ( ) –	WORK Phone Number ( ) –	
Email Address			Email Address		

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS *(If Newborn, give birth weight)* **Primary:**		**Other:**
SEVERITY/COMPLICATIONS/CHRONICITY		
HISTORY		
TREATMENT PLAN (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)		
What care will this client need? ☐ **HOSPITAL** ☐ **HOME CARE** ☐ **Other** (explain) -		Requested Coverage Begin Date
PROGNOSIS:		

HOSPITAL Name			Hospital Case Record Number	
Hospital Contact Person (Name and Title)			Hospital Phone Number ( ) –	
PHYSICIAN'S Name (Print)			Physician's Phone Number ( ) –	
Physician's Address (Number and Street)			Physician's Signature ***(REQUIRED)***	Date Signed
City	State	ZIP Code		

For CSHCS Use Only

☐ **APPROVED** - **The client must now complete enrollment process for coverage.** This client is **medically eligible** for the CSHCS Program for diagnosis code(s):

_____

☐ **DISAPPROVED** - This client is **NOT** medically eligible for the CSHCS Program. Reason:

_____

☐ Eligible for diagnostic evaluation at: _____

_____

☐ Pending / Other:

CSHCS Signature Date

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.
Call 800-642-3195 (TTY 866-501-5656).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-642-3195 (TTY 866-501-5656).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-642-3195 (رقم هاتف الصم والبكم: 866-501-5656).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 800-642-3195 （TTY 866-501-5656）
Syriac (Assyrian)	ܬܘܫܥܢܐ: ܐܝ ܒܣܦ ܠܗ ܡܠܝ ܐܬ ܡܫܝܚܐ ܠܐ ܐܢ ܐܬ ܡܬܬܥ ܒܗ ܡܠܝ ܐܬ ܡܫܝܚܐ ܒܠܫܢ ܐܬ ܡܬܬܥ ܒܗ ܡܠܝ ܐܬ ܡܫܝܚܐ

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: Title V of the Social Security Act
COMPLETION: Completion is voluntary but is required if coverage under the Children's Special Health Care Services program is desired.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages.

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services, you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form-(AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

Michigan Department of Health and Human Services

Medical Justification for Enteral Therapy

If faxed, this form MUST be submitted with a completed MSA-1653-B, including all requested enteral therapy procedure codes.

The Durable Medical Equipment (DME) provider can only provide answers to the following fields: Beneficiary ID Number, First and Last Name, Date of Birth (DOB), type of enteral formula therapy requested, and formula requested. The ordering practitioner or practitioner's designated clinical staff (e.g., dietician, registered nurse, or other appropriate hospital clinical staff) must complete all other fields. Form must be typewritten.

1. Beneficiary ID Number:	2. Date of Birth:
3. Beneficiary Name (First):	4. Beneficiary Name (Last):
5. Diagnosis/Patient History (related to the need for formula):	
6. Height and Weight (current within 30 days of request):	7. Date Measured:
8. Current BMI (weight/height ratio if < 3 years old):	
9. Height (in, cm) and Weight (lb, kg) Change Over Time:	
10. For coordination of care purposes, are there any other insurances or programs covering formula for this beneficiary? ☐ No ☐ Yes. If yes, please indicate the insurance or program and formula.	

Enteral Formula Number 1			
11. Type of Enteral Therapy Requested:	☐ Formula	☐ Thickener	☐ Relizorb
12. Route of Administration:	☐ Oral	☐ Tube Feed	
13. Formula Requested:	14. Type of Diet:		
15. Total Daily Caloric Requirement:	16. Amount/Day (Calories) of Formula:		
17. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:			

Enteral Formula Number 2			
18. Type of Enteral Therapy Requested:	☐ Formula	☐ Thickener	☐ Relizorb
19. Route of Administration:	☐ Oral	☐ Tube Feed	
20. Formula Requested:	21. Type of Diet:		
22. Total Daily Caloric Requirement:	23. Amount/Day (Calories) of Formula:		
24. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:			

Enteral Formula Number 3			
25. Type of Enteral Therapy Requested:	☐ Formula	☐ Thickener	☐ Relizorb
26. Route of Administration:	☐ Oral	☐ Tube Feed	
27. Formula Requested:	28. Type of Diet:		
29. Total Daily Caloric Requirement:	30. Amount/Day (Calories) of Formula:		
31. Economic alternatives tried (i.e. high calorie shakes, OTC supplements, blended foods), if specialty formula, what is the medical contraindication to using standard less costly alternatives:			

32. Ordering Practitioner Name:	33. Ordering Practitioner Specialty/Subspecialty:
34. Ordering Practitioner Signature:	35. Date:

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary but is required if payment from applicable program is sought.

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MEDICAL NEEDS

Michigan Department of Health and Human Services

INSTRUCTIONS: To be completed annually by a physician, nurse practitioner, physical or occupation therapist. Please print or type.

Case Name				
Case Number		Recipient ID Number		
Patient's Name			Patient's Birth Date	
County	District	Section	Unit	Specialist
Specialist		Specialist Phone Number ( )		

Medical Provider:
We would appreciate your cooperation in completing the spaces checked below. In addition to a physician, Box A may be completed by a physician's assistant, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist. Providers must be Medicaid enrolled. An addressed, prepaid envelope is enclosed for your convenience.

You are hereby authorized to release the information requested below to the Michigan Department of Health and Human Services.

Patient's or Representative's Signature	Patient's Name	Signature Date
Authorized Specialist's Signature	Signature Date	Local MDHHS Office

☐ **A**	Pregnancy Delivery (Expected) Date	Number of medically verified unborn children
☐ **B**	Diagnosis(es) / Treatment plan for this patient	
☐ **C**	Chronic ongoing illness ▶ ☐ YES ☐ NO	
☐ **D**	Estimated number of office or clinic visits times per ☐ week ☐ month ☐ quarter ☐ Other (Please Specify)	Will this change? ☐ YES, When _____ (Date) ☐ NO
☐ **E**	Give estimated number of months for the diagnosis in B that medical treatment will be required ☐ Lifetime	
☐ **F**	Is the patient non-ambulatory? ☐ YES ☐ NO	If Yes, explain:
☐ **G**	Does patient need special transportation? If Yes, indicate mode of transportation needed (e.g., van with wheelchair lift, ambulance, etc.) ☐ YES ☐ NO ▶	
☐ **H**	Does someone need to accompany the patient to the medical appointment? ☐ YES ☐ NO ▶	If yes, who / why?
☐ **I**	Do you certify the patient has a medical need for assistance with any of the personal care activities listed below? ▶ ☐ YES ☐ NO Eating, Toileting, Bathing, Grooming, Dressing, Transferring, Mobility, Taking Medications, Meal Preparation, Shopping, Laundry, Housework	Check any complex care services needed. ☐ Specialized Feeding ☐ Suctioning ☐ Catheters or Leg Bags ☐ Bedsore Prevention ☐ Colostomy Care ☐ Range of Motion ☐ Bowel Program ☐ Other
☐ **J**	Can Patient work at usual occupation? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long): Can Patient work at any job? ☐ YES ☐ YES, but with limitations (Specify below) ☐ NO (How long):	
☐ **K**	Other (Explain)	
☐ **L**	Is the spouse or parent of the above disabled individual needed in the home to provide care? ☐ YES ☐ NO Spouse or parent cannot engage in work due to the extent of care required. ☐ YES ☐ NO How long:	

Date patient was last seen	Are you a Medicaid enrolled provider? ☐ YES ☐ NO
Name and title (Print or type)	MA enrolled Provider Signature
National Provider Identifier (NPI) Number	Signature Date / Telephone Number

AUTHORITY: Federal 45 CFR of 233.20, CFR 440.10 and CFR 440.20
COMPLETION: Voluntary
PENALTY: Benefits may be affected.

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DCH-3878, MENTAL ILLNESS/INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

(For Use in Claiming Exemption Only)

Michigan Department of Health and Human Services

Level II Screening

(Revised 3-22)

SECTION 1 - INSTRUCTIONS

- Must be completed, signed, and dated by a nurse practitioner, physician's assistant, or physician.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies.

SECTION 2 – GENERAL INFORMATION

Patient Name | Date of Birth

Name of Referring Agency | Referring Agency Telephone Number

Referring Agency Address (Number, Street, Building, Suite Number, etc.)

City | State | Zip Code

SECTION 3 – EXEMPTION CRITERIA

☐ **COMA**

Yes, I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA**

Yes, I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below.

Yes, I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness.

Yes, I certify the patient under consideration does not have an intellectual disability, developmental disability, or a related condition.

Specify the type of dementia

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts, and similar tasks.
   - Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family, and job-related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia, and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.

3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities, or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.
5. **EITHER**
   a. Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, **OR**
   b. An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **HOSPITAL EXEMPTED DISCHARGE**

Yes, I certify that the patient under consideration:

1. is being admitted after an inpatient medical hospital stay, AND
2. requires nursing facility services for the condition for which he/she received hospital care, AND
3. is likely to require less than 30 days of nursing services.

Physician/Physician Assistant/Nurse Practitioner Signature and Credentials Date

Name (Typed or Printed) Telephone Number

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

COPY DISTRIBUTION:

ORIGINAL- Nursing Facility retains in patient file
COPY - Attach to form DCH-3877 and send to Local Community Mental Health Services Program (CMHSP)
COPY - Patient Copy or Legal Representative

INSTRUCTIONS FOR COMPLETING LEVEL II SCREENING

The **DCH-3878** is to be used ONLY when the individual identified on a **DCH-3877, Preadmission Screening (PAS)/Annual Resident Review (ARR)** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, he/she may be admitted or retained at a nursing facility without additional evaluation. However, a completed copy of the DCH-3878 must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

Must be completed, signed, and dated by a nurse practitioner, physician's assistant, or physician.

Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use an **"X"** to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia.
- Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability, or a related condition.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type
2. Vascular Dementia
3. Dementia due to Other General Medical Conditions
4. Substance - Induced Persisting Dementia
5. Dementia Not Otherwise Specified
6. Lewy Body Dementia

Michigan Recuperative Care Provider Attestation Form

Michigan Department of Health and Human Services

Provider Information

Provider Name	Provider National Provider Identifier (NPI) Number		
Service Location Address	City	State	Zip Code

Contact Name
Office Phone Number
Office Fax Number

Recuperative care is a transitional program for eligible Medicaid beneficiaries who are experiencing homelessness and are too ill or frail to return to their living environment, but are not ill enough to continue to need hospital-level care or skilled nursing care. Recuperative care is a short-term program that allows these beneficiaries to recover post-hospitalization, receive case management services, room and board, access medical care or other Medicaid services, and supportive services.

The recuperative care provider must meet all the following to enroll, participate and bill Michigan Medicaid for recuperative care services.

I attest that our setting meets the following criteria to administer a recuperative care program in the State of Michigan.

Initials (do not use Xs or checkmarks) are required.

Our setting has the following:

_____Meets the National Institute for Medical Respite Care (NIMRC) standards for medical respite care programs (https://nimrc.org/standards-for-medical-respite-programs/).
_____Private or semi-private rooms for beneficiaries.
_____Allow 24-hour access to rooms.
_____Clean linens for each beneficiary upon admission.
_____At least three meals per day provided.
_____Secure place to store personal belongings.
_____Secure medication storage accessible by the beneficiary.
_____Appropriate storage for all durable medical equipment.

_____On-site access to laundry and shower facilities.

_____24-hour access to staff, and staff on-site that are minimally trained in first aid and basic life support on-site always.

_____Written policies to allow beneficiary visitors to enter the facility/room.

_____Written policies and procedures for life-threatening emergencies.

_____A facility that is compliant with local and state fire safety standards.

_____A facility that is compliant with federal Americans with Disabilities Act (ADA) requirements and that meets the individual beneficiary's functional needs.

_____I attest that we will have the appropriate providers available based on the member's plan of care (POC). These will include one or more of the following: registered nurse, licensed practical nurse, case manager, mental health counselor, social worker, or community health worker.

An administrator, manager, director, or other person authorized to sign must initial each applicable statement. Write the name and title of the person signing this attestation statement. This person must be disclosed to MDHHS on the Disclosure of Ownership and Control Interest of an Entity or in the Owners and Authorized Persons section of the Michigan Provider Screening and Enrollment application.

I attest to the accuracy of all information on this form.

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature.

Authorized Officer Name (Print or Type)	Authorized Officer Title
Authorized Officer Signature	Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary but is required if payment from applicable program is sought.

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Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Completion Instructions

This form should be completed for NEW or REPLACEMENT mobility device(s) and seating systems. It must be submitted with the Complex Seating and Mobility Device Prior Approval - Request/Authorization (MSA-1653-D). The evaluation and justification must be submitted within 90 days of the date the evaluation was completed.

The appropriate Addendum(s) must accompany the MSA-1656 & MSA-1653-D.

BENEFICIARY INFORMATION: Complete beneficiary name, date of birth, sex, **mihealth** number, ordering physician and physician specialty. The beneficiary name and **mihealth** number must be entered at the top of each subsequent page.

SECTIONS 1 THROUGH SECTION 11 MUST BE COMPLETED BY A LICENSED/CERTIFIED MEDICAL PROFESSIONAL.

NOTE: A licensed/certified medical professional means an occupational or physical therapist, a physiatrist or rehabilitation RN who has at least two years' experience in rehabilitation seating; and is not an employee of, or affiliated in any way with, the Medical Supplier with the exception of hospitals with integrated delivery models that include the supplier of the equipment and the provider of the clinical evaluation. A PTA or OTA may not evaluate for, complete or sign this document.

SECTION	INSTRUCTIONS
1	Indicate the beneficiary name, mihealth number, ordering/referring physician name, specialty and National Provider Identifier (NPI).
2	Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. The acronym "WFL" means "within functional limits."
3	Home Environment questions reflect the current setting in which the beneficiary lives.
4	Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school, if applicable. Indicate if the mobility equipment fits into the vehicle and if the family can lift the mobility equipment into a vehicle.
5	This information reflects the need for pressure relief. If the beneficiary has current decubiti, the evaluator should indicate the stage as defined by the **National Pressure Ulcer Advisory Panel (NPUAP) at www.npuap.org**.
6	**Mandatory for all requests.** Describes the beneficiary's ADL functional ability without mobility devices. The acronym "UE" means "upper extremity." Answer the items regarding visual perception, problem solving and comprehension only if requesting a power mobility item.
7	Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. Complete the Manual Muscle Test (MMT) for hand only if requesting a power mobility item. This measurement should be of the appropriate hand/digits that will be used to operate specialty controllers. **Modified Ashworth Scale** 0 No increase in muscle tone 1 Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the attached part is moved in flexion or extension 1+ Slight increase in muscle tone, manifested be a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM 2 More marked increase in muscle tone through most of the ROM, but affected part easily moved 3 Considerable increase in muscle tone, passive movement difficult 4 Affected part rigid in flexion or extension H = **Hypotonia** O = **Observation** **Manual Muscle Evaluation** 100% 5 N Normal Complete ROM against gravity with full resistance 75% 4 G Good Complete ROM against gravity with some resistance 50% 3 F Fair Complete ROM against gravity 25% 2 P Poor Complete ROM with gravity eliminated 10% 1 T Trace Evidence of contractibility but no joint motion 0% 0 O Zero No evidence of contractility C = Complete; IC = Incomplete; ∗ = Pain

<table>
<tr><th>SECTION</th><th colspan="2">INSTRUCTIONS</th></tr>
<tr><td></td><td colspan="2">If evaluator is not able to test beneficiary due to cognition, age, etc., then information for MMT can be based on observation (not on self-report).</td></tr>
<tr><td>8</td><td colspan="2">Check all items that apply for mobility goals. Section is to be used if evaluator has any other comments to establish medical need, functional goals, etc.</td></tr>
<tr><td>9</td><td colspan="2">Evaluator should list all equipment the beneficiary currently owns or uses. Include brand, model, serial number, description and date of purchase/rental.</td></tr>
<tr><td>10</td><td colspan="2">To be completed if beneficiary is in a nursing facility. This section should be completed and signed by the Director of Nursing, Facility Administrator or Ordering/referring Physician. This page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the MDHHS Program Review Division.</td></tr>
<tr><td>11</td><td colspan="2">To be completed by the evaluator and, if applicable, all team members involved in the evaluation. Enter date of evaluation, evaluator’s name, title, telephone number, place of employment and address. If team evaluation, in Section 11, list all participants and titles (attach additional pages if necessary). The attestation page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the Michigan Department of Health and Human Services (MDHHS) Program Review Division.</td></tr>
<tr><td rowspan="3">Notes</td><td colspan="2">The applicable addendums must accompany the MSA-1656 & MSA-1653-D when requesting the authorization. Failure to include the appropriate addendum(s) may cause a delay in the authorization process.</td></tr>
<tr><td>Addendum A: To be completed when requesting new or replacement manual wheelchairs with accessories, power mobility devices, and/or seating systems.</td><td>Addendum B: To be completed when requesting new or replacement strollers, standers, gait trainers and children’s positioning chairs.</td></tr>
<tr><td colspan="2">Note:
For beneficiaries residing in a nursing facility, return the completed MSA-1656, addendum(s) and MSA-1653-D to the requesting nursing facility.
For beneficiaries in the community, the MSA-1656, addendum(s) and MSA-1653-D are forwarded to the ordering physician for their review.</td></tr>
</table>

SUBMIT TO:

Michigan Department of Health and Human Services
Program Review Division
PO Box 30170
Lansing, Michigan 48909 **Fax: (517) 335-0075**

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices

This form must be completed by physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. Incomplete information will result in the form being returned to the evaluator for completion.

SECTION 1: BENEFICIARY INFORMATION

Beneficiary Name: _____ mihealth Number: _____
Ordering/Referring Physician: _____ NPI: _____
Physician Specialty:

SECTION 2: MEDICAL HISTORY

Primary Diagnosis: _____ Onset date:	Secondary Diagnosis: _____ Onset date:

If spinal cord injury or spina bifida indicate the level of injury/impairment:

Relevant past and future surgeries:

Bowel Mgmt: ☐ Continent ☐ Incontinent ☐ Colostomy (Indicate type):

Bladder Mgmt: ☐ Continent ☐ Incontinent ☐ Catheter (Indicate type):

Cardio Status: ☐ WFL ☐ Impaired	Neuro Status: Seizures ☐ YES ☐ NO If YES, Frequency/Duration: /	Respiratory Status: ☐ WFL ☐ Impaired
Baclofen pump present? ☐ YES ☐ NO If YES, date Implanted: _____ Botox? ☐ YES ☐ NO If YES, date of last injection: _____ Other explain:		Sip 'N Puff controller requested? ☐ YES ☐ NO If YES, additional information maybe be required:
Height: _____ Weight: _____	Explain recent changes or trends in weight:	

List medication(s) currently prescribed:

How does the management or severity of the above conditions/impairments affect the need for the equipment requested?

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living /AFC/Group Home ☐ Nursing Facility

Does beneficiary live alone? ☐ YES ☐ NO If NO, does beneficiary have a caregiver? ☐ YES ☐ NO

If YES, who provides the care? ☐ Family member ☐ RN ☐ LPN ☐ Other (explain)

How many hours per day are provided by the caregiver?

SECTION 4: COMMUNITY ADL (Transportation)

What is the beneficiary's mode of transportation? (Check all that apply.)

☐ Car ☐ Van/SUV ☐ Van w/ Lift ☐ Truck ☐ Taxi Cab ☐ Bus ☐ School Bus ☐ Ambulance ☐ Other

Does the beneficiary attend school or work? ☐ YES ☐ NO

Is the beneficiary transported in the current or requested wheelchair? ☐ YES ☐ NO If NO, explain why the beneficiary cannot be transported in the current or requested chair?

Explain:

SECTION 5: SENSATION AND SKIN ISSUES

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hypersensitive	**Pressure Relief** ☐ Dependent ☐ Independent ☐ Type of assistance needed How does the beneficiary perform pressure relief?	
Does beneficiary have a history of skin decubiti and/or flap surgery? ☐ YES ☐ NO If YES, indicate location:	Does beneficiary have a current decubiti? ☐ YES ☐ NO If YES, describe:	Does beneficiary have other skin issues? ☐ YES ☐ NO If YES, describe:

Beneficiary Name: _____ mihealth Number: _____

SECTION 6: MOBILITY ASSESSMENT *(Mandatory for all requests)*

Functional Ability Without Mobility Device(s)

Sitting:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Standing:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Transfers:

☐ Independent ☐ Type of assistance needed:

How does beneficiary transfer:
- ☐ Pivot
- ☐ Sliding
- ☐ Mechanical Lift
- ☐ Other: (Explain)

Ambulation within 1 minute:
- ☐ Independent > or = 150 ft.
- ☐ Ambulates with assist > or = 150 ft. Explain type of assistance:
- ☐ Ambulates with device > or = 150 ft.
- ☐ Ambulates short distance only ____ ft.
- ☐ Unable to ambulate
- ☐ Limited due to endurance - Explain:

Explain how this affects equipment ordered?

Complete only if power mobility item is requested (e.g., power wheelchair, scooter, power assisted wheels, etc.)

Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested. ☐ YES ☐ NO

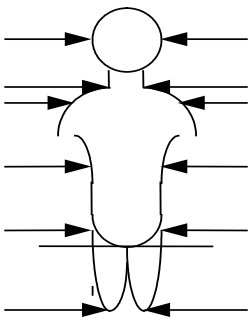
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. ☐ YES ☐ NO
If beneficiary is unable, who will complete? Explain:

Comprehension: Understands and is able to follow directions and conversations that are complex or abstract; understands either spoken or written language. ☐ YES ☐ NO
If NO, explain:

SECTION 7: MODIFIED ASHWORTH SCALE AND MANUAL MUSCLE EVALUATION INFORMATION

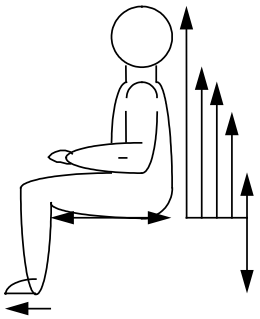
See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the:



Head: ____
Neck: ____
Shoulder: ____
Trunk: ____
Hips: ____
Feet: ____

Height:



	L	R
Crown:	____	____
Occiput:	____	____
Shoulder:	____	____
Axilla:	____	____
Elbow:	____	____
Seat Depth:	____	____
Leg Length:	____	____
Foot Length:	____	____

Primitive reflexes present:
- ☐ Asymmetrical Tonic Neck Reflex
- ☐ Symmetrical Tonic Neck Reflex
- ☐ Startle Reflex
- ☐ Other; Explain:

Explain how this relates to equipment ordered:

Beneficiary Name: _____ mihealth Number: _____

Head & Neck	☐ Maintains upright without support ☐ Maintains upright with support ☐ Flexed ☐ Extended ☐ Rotated ☐ Laterally Flexed ☐ Cervical Hyperextension ☐ Absent head control			
	ROM (Range of Motion) ☐ AROM ☐ AAROM ☐ PROM **Left** **Right**	**MMT/O** (Manual Muscle) ☐ Test ☐ Observation **Left** **Right**	**TONE**	Explain how this affects equipment ordered:
Shoulder	____ Flexion ____ ____ Abduction ____ ____ Internal Rotation ____ ____ External Rotation ____	____ Flexion ____ ____ Abduction ____ ____ Internal Rotation ____ ____ External Rotation ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Elbow	____ Flexion ____ ____ Extension ____ ____ Pronation ____ ____ Supination ____	____ Flexion ____ ____ Extension ____ ____ Pronation ____ ____ Supination ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Wrist	____ Flexion ____ ____ Extension ____	____ Flexion ____ ____ Extension ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Hand	____ Grip Strength ____ ____ Pinch Strength ____			
Knee	____ Flexion ____ ____ Extension ____	____ Flexion ____ ____ Extension ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Ankle & Foot	____ Dorsiflexion ____ ____ Plantarflexion ____ ____ Inversion ____ ____ Eversion ____	____ Dorsiflexion ____ ____ Plantarflexion ____ ____ Inversion ____ ____ Eversion ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia ☐ Clonus: ☐ Left ☐ Right	

SECTION 8: GOALS

Check all that apply.

- ☐ Independence with mobility in the home and mobility related activities of daily living (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- ☐ Assisted mobility/occasional assistance with wheelchair propulsion (e.g., verbal cueing, pushing up a ramp or onto a bus, over curbs, etc.)
- ☐ Dependent mobility
- ☐ Optimize pressure relief
- ☐ Proper positioning and/or correction of a physiological condition. Explain:
- ☐ Other: (Explain)

SECTION 9: LIST TYPE OF EQUIPMENT PRESENTLY OWNED OR USED BY THE BENEFICIARY

Brand	Model	Serial Number	Description	Date of Purchase

Beneficiary Name: _____ mihealth Number: _____

SECTION 10: MOBILITY ASSESSMENT - FOR BENEFICIARIES IN A NURSING FACILITY ONLY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or ordering/referring physician.

Nursing Facility Name:		NPI:	Date of Admission:
Mobility History:	☐ Uses nursing facility per diem chair	☐ Uses own personal chair	
Wheelchair Description: *(Currently used or owned)*	Brand:	Model No:	Serial No:
	Components:		

Customized Wheelchair Documentation (Required documentation to accompany this form)

☐ Most Recent MDS ☐ Past Two Months of Nursing Notes ☐ Current Plan of Care that relates to the equipment ordered

Director of Nursing Signature Date

Print Name

Ordering Physician Signature Date

Print Name

SECTION 11: EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 9, and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Enter Date Here
Evaluation Date

Enter Text Here
Evaluator Name/Title (Print)

Enter Text Here
Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum A: Mobility/Seating

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The evaluator must complete requested and/or current equipment, warranty information and economic alternative information.
NOTE: Only complete sections that apply to the requested equipment/accessories.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION(s)	☐ Requested	☐ Current ☐ None
Manual wheelchair with accessory add-ons.	☐ Propels a wheelchair 60 feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade, maneuvers on rugs and over door sills ☐ Cannot propel manual wheelchair without caregiver assist. ☐ Cannot propel manual wheelchair, used for transport only. ☐ Medical reason for power assisted wheels: Chair width _____inches. Chair depth _____inches. ☐ Tilt ☐ Tilt & Recline Medical reasons for function indicated: Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Power wheelchair with standard joystick	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, explain: Chair width _____inches. Chair depth _____inches. **Power** functions requested: *(Check all that apply.)* ☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests ☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests ☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance? ☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions? ☐ YES ☐ NO Has pressure relief plan of care with equipment? If YES, (explain) _____ Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)* **Manual** functions requested: ☐ Tilt ☐ Tilt & Recline

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

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Beneficiary Name: _____ Mihealth Number: _____

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	
Power wheelchair with alternate controls	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, please explain: Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Power functions requested: *(Check all that apply.)*

☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests
☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests

Manual functions requested:
☐ Tilt ☐ Tilt & Recline

☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance?
☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions?
☐ YES ☐ NO Has pressure relief plan of care with equipment?

Explain:

Specify control needed:

Medical need for control indicated:

Indicate the beneficiary's ability to use in their environment:

Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____

	☐ Requested	☐ Current ☐ None
Power wheelchair standing feature	☐ Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back ☐ Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating ☐ Pressure relief is done by the beneficiary without assistance If assistance with pressure relief is required, indicate amount and frequency needed: _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Chair width _____inches. Chair depth _____inches.

Indicate current pressure relief plan of care (including frequency and duration):

Is beneficiary/caregiver compliant with current pressure relief plan of care? ☐ YES ☐ NO

If NO, explain:

Beneficiary Name: _____ Mihealth Number _____

Equipment	☐ Requested	☐ Current ☐ None
Scooter	☐ Able to propel manual wheelchair _____ feet. ☐ Independent trunk balance, ☐ Adequate bilateral hand functions to work tiller. Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

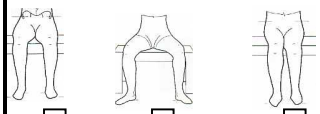
	Device Type *(attach additional page(s) if necessary)*	
All Accessories / Add Ons	☐ Head & Neck	☐ Feet ☐ Footbox
	☐ Arms	☐ Other - Describe
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Growth adaptability of device	**Requested**	**Current**
REQUIRED	Seat width: (inches) _____	Seat width: (inches) _____
	Back height: (inches) _____	Back height: (inches) _____
	Seat depth: (inches) _____	Seat depth: (inches) _____
	Maximum frame growth: (inches)	Maximum frame growth: (inches)

Beneficiary Name: _____ Mihealth Number _____

SEATING SYSTEM

Medical/functional Reason
☐ New growth > 3 inches depth and/or > 2 inches width
☐ Change in width and depth; width inches _____ depth in inches _____
☐ Orthopedic change; explain: _____
☐ Needs corrective forces to assist with maintaining or improving posture. _____
☐ Accommodate beneficiary's posture (e.g., current seating postures are not flexible, etc.). _____
☐ Other medical changes that affect the need for new positioning; specify: _____

POSTURE:				**COMMENTS:**
	Lateral View	AP View	Superior View	
TRUNK	Anterior / Posterior ☐ WFL Kyphosis ☐ ↑ Thoracic Lordosis ☐ ↑ Lumbar Lordosis ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Left Right ☐ WFL ☐ Convex Left ☐ Convex Right ☐ c-curve ☐ s-curve ☐ multiple ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Rotation-shoulders and upper trunk ☐ Neutral ☐ Left anterior ☐ Right anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	☐ Hypertonia ☐ Hypotonia
	Anterior View	Superior View	ROM	MMT/O
HIPS	Position  ☐ Neutral ☐ Abduct ☐ Adduct ☐ Fixed ☐ Subluxed ☐ Partly Flexible ☐ Dislocated ☐ Flexible	Windswept ☐ Neutral ☐ Right ☐ Left ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Hip Flexion/Extension Limitations: (PROM in Degrees) Hip Internal/External Range of Motion Limitations:	
	Lateral View	AP View	Superior View	
PELVIS	Anterior / Posterior ☐ Neutral ☐ Posterior ☐ Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Obliquity ☐ WFL ☐ R elev ☐ L elev ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Rotation-Pelvis ☐ WFL ☐ Right Anterior ☐ Left Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	If spinal curvature present, indicate degree.

Beneficiary Name: _____ Mihealth Number _____

Requested Seating System		Current Seating System ☐ None	
Length of warranty? _____ Mobility device to be used with:		Length of warranty: _____ Warranty begin date: _____ Mobility device is used with:	
☐ Planar/Non-custom contour	☐ Custom *	☐ Planar/Non-custom contour	☐ Custom *
Manufacturer:	Type:	Manufacturer:	Type:
Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat
Lateral Components Include: ☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	Lateral Components Include: ☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	Lateral Components Include: ☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	Lateral Components Include: ☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust
Other Components - List:	Other Components - List:	Additional Components: ☐ Yes ☐ No If Yes, describe:	Additional Components: ☐ Yes ☐ No If Yes, describe:
If requesting custom seating, specify why planar/non-custom contour does not meet beneficiary's medical needs.			

* For definition of custom refer to MDHHS Medicaid Provider Manual, Medical Supplier Chapter, sections Standard Equipment and Custom-Fabricated Seating, and section Standards of Coverage

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum A and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment information, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	
Stroller	☐ Transport only ☐ Primary mobility device Indicate medical special needs for use and adaptions needed: .	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Gait trainer *(if less than age 21)*	☐ Is independent with gait trainer. ☐ Requires assistance with mobility using gait trainer. Describe: How many times per day will beneficiary use gait trainer: How far can beneficiary ambulate with gain trainer/device? _____ft. Indicate the expected performance with the requested equipment: Is beneficiary/caregiver compliant with current mobility plan of care? ☐ Yes ☐ No If No, explain:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Children's positioning chairs *(if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.*	☐ Home inaccessible to mobility device. ☐ Beneficiary is > 40 lbs. with limited head and trunk control ☐ Beneficiary has current active seizures ☐ Beneficiary is unable to eat or be safely fed in current mobility device ☐ Crown to hip measurement on Mat evaluation is > 26" If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical/functional needs:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

Beneficiary Name: _____ Mihealth Number: _____

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	**Where device is used**
Car seat	Indicate medical special needs for use and adaptions needed:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

	☐ Requested	☐ Current ☐ None
Stander *(If less than age 21)*	☐ Is dependent with standing ☐ Walks with assistive device ☐ Walks with gait trainer ☐ Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	Indicate current standing plan of care (including how many times per day and how long):	
	Is the beneficiary/caregiver compliant with standing plan of care? ☐ YES ☐ NO If NO, explain:	

	☐ Requested	☐ Current ☐ None
Growth adaptability of device	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility:	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility:

Equipment	**Device Type** *(attach additional page(s) if necessary)*	**Medical Reason**
All Accessories / Add Ons	☐ Head & Neck Type:	
	☐ Arms Type:	
	☐ Feet Type:	
	☐ Other - Describe	
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Beneficiary Name: _____ Mihealth Number: _____

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

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Michigan Department of Health and Human Services

NURSE AIDE TRAINING AND TESTING PROGRAM INTERIM REIMBURSEMENT REQUEST

Interim reimbursement request data is used to establish the amount of per diem add-on reimbursement to be included in the Medicaid Program per diem payment rate. The total amount of add-on reimbursement for the nurse aide training and testing program during the fiscal year will be adjusted through the annual settlement determination of the training and testing costs apportioned to Medicaid inpatient days.

Information included in this request may reflect estimated costs and projections for the time period indicated.

Send completed request to: DARS@michigan.gov

NOTE: Review detailed "Instructions" on page 3.

1. Provider Cost Period **From:** **To:**		3. Name of Training Contractor (if used)	
2. Training Conducted By ❑ **In-House Staff** ❑ **Centralized Training** ❑ **Outside Contractor** (complete items 3, 4 & 5) **From:** **To:**		4. Contractor Address	
		5. City	State / Zip Code

6. Was the facility designated a "LOCKOUT FACILITY" by the Department of Licensing And Regulatory Affairs at any time during the cost reporting period?

❑ **NO** ❑ **YES** **From:** **To:**

7. Estimated Nurse Aide Training Program Costs for the Period (from Page 2, Line 11) . . . . . _____

8. Estimated Total Inpatient Days for the Period . . . . . _____

9. Estimated Nurse Aide Training Program Cost Per Day (line 7 divided by line 8) . . . . . _____

CERTIFICATION STATEMENT: To be Signed by Provider and/or Authorized Representative

I certify that this claim for adjustment is true, accurate, and prepared with my knowledge and consent, and does not contain untrue, misleading or deceptive information. In the event the actual allowable costs do not support the increased rate, the provider will reimburse the State for excess amounts received. I further agree that retrospective cost settlements will be made in accordance with the State Plan, as applicable.

10. Signature of Provider and/or Authorized Representative	13. Name of Facility		
	14. Street Address		15. County No.
11. Typed Name	16. City	State **MI**	Zip Code
12. Phone Number	17. NPI No.	18. Provider License No.	

Authority: Title XIX of the Social Security Act.
Completion: Is Voluntary, but is required if Medical Assistance Program payment is desired.

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ESTIMATED NURSE AIDE TRAINING AND TESTING COSTS
Worksheet

NOTE: Review detailed "Instructions" on page 4.

1. Facility Training Staff:			
a. Salaries and Wages			
b. Fringe Benefits			
c. Payroll Taxes			
d. Total Training Staff (1a + 1b + 1c)		**1**	0
2. Nurse Aide Training Consultants		**2**	
3. Nurse Aide Student Staff:			
a. Wages			
b. Fringe Benefits			
c. Payroll Taxes			
d. Total Student Staff (3a + 3b + 3c)		**3**	0
4. Training Program Supplies		**4**	
5. Training Program Transportation:			
a. Training Staff			
b. Student Staff			
c. Total Transportation (5a + 5b)		**5**	0
6. Outside Contracted Approved Nurse Aide Training:			
a. Paid Directly by Facility			
b. Reimbursed to Employee Staff			
c. Total Outside Training (6a + 6b)		**6**	0
7. Nurse Aide Testing Fees:			
a. Paid Directly by Facility			
b. Reimbursed to Employee Staff			
c. Total Testing Fees Paid (7a + 7b)		**7**	0
8. Other Training Program Costs (Specify):			
a.		**8a**	
b.		**8b**	
9. Total Training Program Cost Before Equipment Allowance (Sum of Lines 1 thru 8b)		**9**	0
10. Training Program Equipment Use Allowance: (equipment specific to training program)			
a. Number of months in reporting period			
b. Reporting period training program use allowance.			
Line 10.a. 0 divided by **12**, times **15%** =	**0.00%**		
c. Equipment purchased in Current Year (CY) and Prior 6 years:			
CY minus 6 years $	times Line 10.b.% = 0		
CY minus 5 years $	times Line 10.b.% = 0		
CY minus 4 years $	times Line 10.b.% = 0		
CY minus 3 years $	times Line 10.b.% = 0		
CY minus 2 years $	times Line 10.b.% = 0		
CY minus 1 year $	times Line 10.b.% = 0		
Current Year $	times Line 10.b.% = 0		
d. Total equipment use allowance (Sum of 10.c. line amounts)		**10d**	0
11. Estimated Total Nurse Aide Training Program Costs (Sum of Line 9 and Line 10d.)		**11**	0

MSA-1324 INSTRUCTIONS (REQUEST)

PURPOSE

This form is for the provider to obtain Medicaid Program reimbursement outside the routine nursing care rate per diem for OBRA nurse aide training and testing programs. The form must be completed in order to receive interim reimbursement for those providers that have been determined to be a lockout facility, or for those facilities incurring costs in excess of interim reimbursement. Costs will be retrospectively settled to reflect the Medicaid Program's appropriate share of actual allowable training and testing costs.

Training and testing program costs claimed for services and supplies furnished to or purchased by the facility from organizations related to the provider by common ownership or control must adhere to the related party allowable cost principles. Expenses for such transactions should not exceed expenses for like items or services in an arms-length transaction with other non-related organizations, or the cost to the related organization.

Administrative overhead costs and space costs in nursing facilities conducting in-house training are not considered training and testing program costs. The costs reported must be specifically incurred in conducting the approved nurse aide training and testing program.

Supporting accounting records such as class attendance rosters or training participation logs, purchase orders, vendor invoices, contracts, documentation verifying amounts reimbursed to employees for approved training program expenses incurred by the employee prior to employment at the facility (e.g., canceled check, training program receipt) must be maintained for audit purposes. Supporting materials should be readily identifiable as training related cost documentation and must indicate the type of training involved.

Training Program Approval Requirement - Only costs incurred relative to a Department of Licensing And Regulatory Affairs (LARA) Bureau of Community and Health Systems approved Nurse Aide Training Program may be claimed on this schedule. An approved program may be conducted by the provider's facility or by a separate entity from the provider. The provider **must not report and make a claim** for Medicaid Program reimbursement on this schedule for any costs incurred and associated with providing training **by the lockout facility** during the lockout time period. Allowable nurse aide training program costs during the lockout time period are limited to the costs incurred in obtaining training and testing outside the facility from an approved nurse aide training program.

Note: If the facility maintains separate cost center reporting for the training program, enter the appropriate costs as identified.

ITEM EXPLANATION

1. Provider's Cost Reporting Period
   Enter the fiscal period coinciding with the provider's cost reporting period.
2. Mode of Training
   It is possible that providers may utilize both in-house staff and outside contractors. If a chain organization or group home ownership uses an approved central training program, indicate the training as "in-house" and check "centralized training." If multiple outside contractors are used, indicate each contractor and the time periods utilized.

6. Lockout Facility
   A facility identified by LARA as a "lockout facility" cannot conduct a approved training and testing program, cannot be a training/clinical practice site for another approved program, and cannot conduct clinical skills testing. The facility is notified of the lockout determination action by LARA.

8. Estimated Total Inpatient Days for the Period
   Indicate the appropriate number of LTC total inpatient days of care estimated to be rendered during the time period reported on this form.

13. Name of Facility
    Enter the provider name under which Medicaid payments are issued to the provider.

15. County Number
    Enter the two-digit county number.

14-16. Provider Location
    Enter street address, city (village and/or township) and zip code of the facility's physical location.

17. Provider NPI Number
    Enter the Nursing Facility's ten-digit provider NPI number.

18. Provider's License Number
    Enter the three-digit license number.

MSA-1324 INSTRUCTIONS (WORKSHEET)

1. **Facility Training Staff**
   Payroll-related costs for facility employees incurred by the approved program's direct training time or the nurse aide training program's preparation time.

2. **Nurse Aide Training Consultants**
   Costs incurred for non-facility staff engaged to provide instruction or consultation for the facility's approved nurse aide training program.

3. **Nurse Aide Student Staff**
   Payroll costs for facility employees incurred while the student is engaged in the approved training program or traveling to and from the off-site approved training location, or is engaged in off-site testing or traveling to and from the off-site testing location.

4. **Training Program Supplies**
   Cost incurred for supplies and materials used in conducting an approved training program.

5. **Training Program Transportation**
   Travel or transportation costs incurred by facility staff conducting the approved training program activity and testing, or for off-site nurse aide training and testing. Identify costs separately for training staff and student staff.

6. **Outside Contracted Approved Nurse Aide Training Program**
   Paid Directly By Facility - Costs incurred to obtain nurse aide training through an outside entity approved training program. Payment for subject training is made directly from the nursing facility to the training entity and the nurse aide trainees are employed by the nursing facility
   Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for an approved nurse aide training program prior to becoming an employee at the facility. Reasonable and necessary expenses incurred by the employee through participation and completion of a Bureau of Community and Health Systems approved training program for which the aide has made payment are eligible for remuneration. Only the cost of tuition and books are reimbursed. The aide must be hired by a facility within 12 months after incurring this expense. The facility must obtain receipts and retain documentation from the employee to verify the expense.

7. **Nurse Aide Testing Fees**
   Paid Directly By Facility - Costs incurred for State-run testing. Payment for testing fees is made directly from the nursing facility to the testing authority for aides employed at the facility.
   Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for State-run testing prior to becoming an employee at the facility. The aide must be hired by a facility within 12 months after paying the testing fee. The facility must obtain receipts and retain documentation from the employee to verify the expense.

8. **Other Training Program Costs**
   Costs incurred that are not classified in the identified cost categories 1-7.

   Rental costs for space located off-site of the facility are reimbursable under training and testing only if the space is used solely for the training and testing program. Space costs not meeting this requirement are reimbursable within the plant cost component of Michigan's prospective reimbursement system. Reasonable rental expense for training equipment necessary to the approved training program is an eligible cost.

   Enter the detail and cost of these individual expenses in the yellow shaded cells. The total of these items will be automatically calculated by use of the F9 key.

9. **Total Training Program Cost Before Equipment Allowance**
   Subtotal of Lines 1 through 8b costs. This total will be automatically calculated by use of the F9 key.

10. **Training Program Equipment Use Allowance**
    An annual cost allowance is made for equipment purchased specifically for the Bureau of Community and Health Systems approved nurse aide training program. Such equipment purchases are not included in the plant asset costs of the facility for routine nursing care. An annual allowance of 15 percent of the equipment purchase price is reported as a cost of the training program for as long as the equipment is used in the program, but cannot exceed seven years.

    The use allowance is an annual percentage adjustment made to the 15 percent amount if the cost report period differs from 12 months. Line 10.a. and Line 10.b. will automatically be calculated.

    Enter Line 10.c. the cost of the equipment purchased as required in the yellow shaded cells.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
NURSING FACILITY ISOLATION BED REQUEST FORM

INSTRUCTIONS: Fill out the below table with the facility information and for each beneficiary that you are requesting bed isolation for. This form must be submitted within 5 business days of the return of the isolated individual to their dually certified Medicaid Bed. The request must include the physicians' orders or other relevant documentation to substantiate the need for isolation. This form must be signed at the bottom and sent to MDHHS-NFISOLATION@michigan.gov or by fax to 517-241-0066 if the facility is unable to send an encrypted email. Any questions may be sent to the above email address.

Facility Information

Facility Name	
Facility NPI Number	
Facility CCN Number	
Facility License Number	
Name of the Requestor	
Title of the Requestor	
Email of the Requestor	
Fax Number of the Facility	
Phone Number of the Requestor/Facility	
Date of the Request	

Beneficiary Information

Beneficiary Name	Beneficiary ID	Room Number of the Non-Medicaid Room	Room Number of the Current Room	Start Date	End Date	Number of days in the date range	Reason for Isolation

Authorized Signature Date

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.
Call 800-642-3195 (TTY 866-501-5656).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-642-3195 (TTY 866-501-5656).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-642-3195 (رقم هاتف الصم والبكم: 866-501-5656).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。 請致電 800-642-3195 （TTY 866-501-5656）
Syriac (Assyrian)	ܬܘܼܡܳܪ: ܐܶܢ ܐܲܢ̈ܬ ܡܶܡܠܶܠ ܐ̈ܝܼܬ ܠܶܫܳܢ̈ܳܐ ܣܘܼܪܝܳܝܳܐ، ܐ̈ܝܼܬ ܠܳܟ ܫܘܼܪܬ̈ܳܐ ܕܥܶܕܪ̈ܳܐ ܕܠܳܐ ܡܶܬܚܲܫܒ̈ܳܢ ܠܳܟ ܒܡܶܓܳܢ. ܩܠ̈ܳܝ ܠ 800-642-3195 (TTY 866-501-5656)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-642-3195 (TTY 866-501-5656).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-642-3195 (TTY 866-501-5656).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-642-3195 (TTY 866-501-5656)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 800-642-3195 (TTY ১ 866-501-5656).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-642-3195 (TTY 866-501-5656).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-642-3195 (TTY 866-501-5656).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-642-3195 (TTY 866-501-5656).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-642-3195（TTY 866-501-5656）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-642-3195 (телетайп 866-501-5656).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-642-3195 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 866-501-5656).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-642-3195 (TTY 866-501-5656).

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.

Michigan Department of Health and Human Services
Completion Instructions for MSA-115
Occupational Therapy - Physical Therapy - Speech Therapy
Prior Approval Request/Authorization

General Instructions

The MSA-115 must be used by Medicaid-enrolled outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request prior authorization (PA) for therapy services. MDHHS requires that the MSA-115 be typewritten, handwritten forms will not be accepted. Fill-in enabled copies of this form can be downloaded from the Michigan Department of Health and Human Services (MDHHS) website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The PA request must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed six months for outpatient therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is determination is received.

For complete information on covered services, PA, and documentation requirements, refer to the Therapy Services Chapter of the Michigan Medicaid Provider Manual located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

Attachments/Additional Documentation

All additional attachments/documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's National Provider Identifier (NPI) number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and treatment plan to the PA request.

Form Completion

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
Box 1	MDHHS use only.
Box 2 - 3	The Medicaid enrolled provider's name and NPI.
Box 4 - 6	The provider's telephone number (including area code), address and fax number (including area code).
Box 7- 10	The beneficiary's name (last, first, and middle initial), sex, **mihealth** card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the **mihealth** card and should be verified through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's diagnosis(es) code(s) and description(s) that relate to the service being requested.
Box 13	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.
Box 14 -16	The therapist's name, office telephone number (including area code), and applicable license/certification number.
Box 17	**Initial:** The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under the treatment plan.
Box 18	The date MDHHS approved the last approved prior authorization request for the given diagnosis.
Box 19	The requested date range for which treatment is to be rendered, in a eight-digit format (e.g mm/dd/yyyy to mm/dd/yyyy).

Box Number(s)	Instructions
Box 20	The date treatment was started for the given diagnosis (if treatment was initiated previously).
Box 21	The total number of sessions rendered since the development of the treatment plan.
Box 22	Goals must be measurable. In functional terms, the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs). See Medicaid Provider Manual for additional documentation requirements.
Box 23	Documentation of the beneficiary's progress from the prior period to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary's nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel. See Medicaid Provider Manual for additional documentation requirements.
Box 24	Indicate if the beneficiary is receiving therapy services through the School Services Program.
Box 25	Indicate the treatment plan frequency (e.g., 1x/week, 3x/week, 1x/month, etc.) and duration per visit in 15-minute increments, i.e., units (e.g. 2 units/visit, 4 units/visit, etc.).
Box 26	Complete a separate line for each unique HCPCS code/modifiers combination.
Box 27	The Therapies Database on the MDHHS website lists the HCPCS codes that describe covered services. The database is located at the MDHHS website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The Billing & Reimbursement Chapter in the Medicaid Provider Manual list the required modifiers used to describe covered services for therapy providers. The Medicaid Provider Manual is located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters, & Forms >> Medicaid Provider Manual.
Box 29	The total number of units the service is to be provided during the requested treatment period.
Box 30	The authorized prescribing practitioner must indicate if this is an initial certification or a re-certification and sign and date. Signature is required each time a request is made.
Box 31	The therapist certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.
Box 32-35	MDHHS use only.

Form Submission:
PA request forms for all eligible Medicaid beneficiaries must be submitted electronically*, mailed or faxed to:

MDHHS – Program Review Division
P.O. Box 30170
Lansing, Michigan 48909
Fax Number: **(517) 335-0075**

If submitting electronically, the completed MSA-115 must be uploaded along with the supporting clinical documentation required.

To check the status of a PA request, contact the Program Review Division via telephone at **1-800-622-0276** or electronically via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov.

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.	

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCCUPATIONAL THERAPY - PHYSICAL THERAPY – SPEECH THERAPY PRIOR APPROVAL REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment. All fields must be completed and typewritten.

2. TREATMENT SITE (Medicaid enrolled provider's name)	3. PROVIDER NPI NUMBER	4. PHONE NUMBER
5. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER

7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. MIHEALTH CARD NUMBER	10. BIRTH DATE	11. ADM. DATE

12. ICD DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED	13. ONSET DATE

14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)	15. OFFICE PHONE NUMBER	16. LICENSE/CERTIFICATION NUMBER

17. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ CONTINUING	18. LAST AUTHORIZATION	19. TREATMENT MONTHS / / to / /	20. DATE STARTED	21. # PREV. SESSIONS

22. GOALS (NOTE: SEE MEDICAID PROVIDER MANUAL FOR ADDITIONAL DOCUMENTATION REQUIREMENTS.)

SHORT TERM GOALS	LONG TERM GOALS

23. PROGRESS SUMMARY (NOTE: SEE MEDICAID PROVIDER MANUAL)

24. SCHOOL THERAPY PROGRAMS ☐ YES ☐ NO

25. TREATMENT REQUESTED
FREQUENCY:
DURATION VISIT: (UNITS)

26. LINE NO.	27. PROCEDURE CODE	28. MODIFIER	29. TOTAL UNITS PER PA
01			
02			
03			
04			
05			

30. PHYSICIAN CERTIFICATION

I certify ☐ re-certify ☐ that I have examined the patient named above and have determined that skilled therapy is necessary; that services will be furnished on an in-patient and/or out-patient basis while the patient is under my care; that I approve the above treatment goals and will review every 60 days or more frequently if the patient's condition requires.

PRESCRIBING PRACTITIONER'S NAME (TYPE OR PRINT)

PRESCRIBING PRACTITIONER'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION:
- APPROVED ☐
- RETURNED ☐
- DENIED ☐
- NO ACTION ☐
- APPROVED AS AMENDED ☐

33. AUTHORIZATION PERIOD APPROVED

34. CONSULTANT REMARKS

☐ See CHAMPS

31. THERAPIST CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

THERAPIST'S SIGNATURE DATE

35. CONSULTANT SIGNATURE DATE

Michigan Department of Health and Human Services

Practitioner Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care).

MDHHS requests that the MSA-6544-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. For information on required procedure codes, modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
- CHAMPS Medicaid Code and Rate Reference Tool available in CHAMPS via the External Links menu.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 22	Indicate whether this is the first request for services or if this is a renewal request for ongoing services.
Box 24	Enter a complete description of the services, procedures, etc. requested.
Box 25	Enter the HCPCS Procedure Code.
Box 26	Enter the applicable HCPCS Modifier.
Box 27	Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested.
Box 28	Enter the dates for which the requested procedure or service will take place. Include the dates of travel, if travel assistance will be needed.
Box 29	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description).
Box 30	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked.
Box 32	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS – Behavioral and Physical Health and Aging Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS – Behavioral and Physical Health and Aging Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

PRACTITIONER SPECIAL SERVICES PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. REASON FOR PA REQUEST:

☐ OUT OF STATE CARE ☐ CLINICAL PROCEDURE ☐ OFFICE ADMINISTERED DRUG OR BIOLOGICAL ☐ SURGERY

☐ OTHER _____

3. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	4. NPI NUMBER	5. PHONE NUMBER
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		7. FAX NUMBER

8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	9. SEX ☐ M ☐ F	10. BIRTH DATE	11. MIHEALTH CARD NUMBER

12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)

13. HOSPITAL/ FACILITY NAME	14. HOSPITAL/ FACILITY NPI

15. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	16. NPI NUMBER	17. PHONE NUMBER
18. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		19. FAX NUMBER
20. CONTACT NAME		21. CONTACT PHONE NUMBER

22. ☐ INITIAL REQUEST ☐ RENEWAL REQUEST

23. LINE NO.	24. DESCRIPTION OF SERVICE	25. PROCEDURE CODE	26. MODIFIER	27. QUANTITY	28. ANTICIPATED DATE(S) OF SERVICE
01					
02					
03					
04					

29. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES	30. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE

31. Identify all relevant clinical documentation that has been submitted to support medical necessity: If this is an out-of-state request, in addition to clinical documentation, include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, and C) the plan to transition care back to the state of Michigan.

☐ H&P ☐ PROGRESS NOTES ☐ CONSULTATIONS ☐ LABS

☐ PATHOLOGY REPORT ☐ OPERATIVE REPORT ☐ RADIOLOGY REPORTS ☐ PHOTOS ****INCLUDE PHOTOS FOR ALL COSMETIC AND RECONSTRUCTIVE SURGERIES**

☐ DISCHARGE SUMMARY ☐ LETTER OF MEDICAL NECESSITY ☐ OTHER DIAGNOSTICS:_____

32. **PROVIDER CERTIFICATION:** THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE: DATE:

AUTHORITY: Title XIX of the Social Security Act and Administrative rule 400.1104(a) **COMPLETION:** Is Voluntary but is required if Medical Assistance program payment is desired.	The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

DCH-3877, PREADMISSION SCREENING (PAS)/ ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Developmental Disability/Related Conditions Identification)
Michigan Department of Health and Human Services
Level I Screening
(Revised 3-22)

SECTION 1 – LEVEL I SCREENING

☐ **PAS** ☐ **ARR** ☐ **Change in Condition** ☐ **Hospital Exempted Discharge**

SECTION 2 – PATIENT, LEGAL REPRESENTATIVE AND AGENCY INFORMATION

Patient Name (First, MI, Last)	Date of Birth (MM/DD/YY)	Gender ☐ Male ☐ Female	
Address (number, street, apt., or lot #)	City	State	Zip Code
County of Residence	Social Security Number	Medicaid Beneficiary ID Number	Medicare ID Number
Does this patient have a court-appointed guardian or other legal representative? ☐ No ☐ Yes	If yes, give Name of Legal Representative		
County in which the legal representative was appointed	Legal Representative Telephone Number		
Address (number, street, apt., or lot #)	City	State	Zip Code
Referring Agency Name	Telephone Number	Admission Date (actual or proposed)	
Nursing Facility Name (proposed or actual)	County Name		
Nursing Facility Address (number and street)	City	State	Zip Code

Sections 3 and 4 of this form must be completed by a registered nurse, licensed bachelor, or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

SECTION 3 – SCREENING CRITERIA (All 6 items must be completed.)

1. The person has a current diagnosis of ☐ **Mental Illness** or ☐ **Dementia** (Check one or both)	☐ No	☐ Yes
2. The person has received treatment for ☐ **Mental Illness** or ☐ **Dementia** (within the past 24 months) (Check one or both)	☐ No	☐ Yes
3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.	☐ No	☐ Yes
4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.	☐ No	☐ Yes

5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. ☐ No ☐ Yes

6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual/developmental disability or a related condition. These deficits appear to have manifested before the age of 22. ☐ No ☐ Yes

Note: If you checked "Yes" to items 1 and/or 2, checked the word "**Mental Illness**" and/or "**Dementia**."

If yes, please explain

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION 4 - CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature	Date	Name (type or print)
Degree/License		Telephone Number

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION 3 is "Yes", send ONE copy to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Developmental Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor, or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right-hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility. **Check the appropriate box in the upper right-hand corner.**

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

   Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.

3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.

4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis, and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual/Developmental Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets ALL 4 of the following conditions:

   a. It is manifested before the person reaches **age 22**.

   b. It is likely to continue indefinitely.

   c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

   d. It is attributable to:

      - Intellectual/Developmental Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;

      - cerebral palsy, epilepsy, autism; or

- any condition other than mental illness found to be closely related to Intellectual/ Developmental Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual/Developmental Disability and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

Note: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

Michigan Department of Health and Human Services
Completion Instructions for MSA-0732
Private Duty Nursing Prior Authorization – Request for Services

The MSA-0732 form (page 2) must be submitted every time services are requested, i.e., before services can begin and for each specified authorization period thereafter, no less than 15 days prior to the end of the current authorization period. MDHHS requests that the MSA-0732 be typewritten to facilitate processing.

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage under 21 years of age. Private Duty Nursing is not a benefit under Children's Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician's staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.

Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE UNITS or DECREASE UNITS box only if this request demonstrates an increase or decrease in time from the previous authorization period. Time is authorized and billed in 15-minute incremental units (1 unit = 15 minutes).
3 - 7	PDN provider information. Provide complete agency name, or name of individual (last, first, and middle initial). Designate whether RN or LPN. Include NPI number, phone number, address, and fax number.
8 - 14	Beneficiary information. Provide complete name and birth date (month, day, and year), sex, mihealth card number, complete address, county, and primary diagnosis using the appropriate ICD code only.
15 - 18	Other insurance information if applicable, including name of company and beneficiary's group/policy and certificate/contract numbers.
19 - 25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner if beneficiary is currently hospitalized.
26 - 30	Ordering physician information. Provide complete name (including MD or DO), NPI number, phone number, address, and fax number.
31 - 35	Description of the service(s) to be provided utilizing HCPCS code T1000 and modifier TD for RN or TE for LPN. Use modifier TT if caring for more than one beneficiary. Include the number of total units per month required to provide the service(s) with the start date and end date, if known.
36 - 40 **43 - 49**	Home environment information, including number of siblings residing in the home (include step and foster child(ren) if applicable) and if they receive PDN. Provide child's name and mihealth card number if receiving PDN. Also provide the number of other individuals in the home requiring care (e.g., elderly parent, grandparent, disabled spouse, sibling), name(s) and number of caregivers for the beneficiary for whom services are being requested, and whether the caregiver(s) either work and/or attends school outside of the home. If so, how many hours are spent working and/or attending school. (Additional pages may be required.)
41 - 42	Current school information if child is or will be attending school during the authorization period when PDN services are being provided. Include number of hours per day and per week, including travel time.
50 - 56	If more than one PDN or PDN agency is involved, their name(s), NPI, phone number(s), fax number(s), and which PDN will be managing the care plan (i.e., the provider named in items 3 – 7, or the provider named in this space).
57	List all other services in the home. Failure to disclose all services in the home may result in recoupment of Medicaid dollars for PDN reimbursement.
58	The Provider's signature certifies that (1) the individual PDN or agency requesting the services understands the necessity for obtaining prior authorization for PDN and; (2) the information provided on this form is accurate and complete.
59	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability.
60	MDHHS use only

Form Submission

The completed MSA-0732 (page 2) and required documentation must be mailed or faxed to:

Michigan Department of Health and Human Services **Fax:** (517) 241-7813
Program Review Division
P.O. Box 30170
Lansing, MI 48909

Questions should be directed to MDHHS – Behavioral and Physical Health and Aging Services Administration, Program Review Division via telephone at
1-800-622-0276.

Authority: Title XIX of the Social Security Act	COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.	

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Michigan Department of Health and Human Services

PRIVATE DUTY NURSING
PRIOR AUTHORIZATION – REQUEST FOR SERVICES

1. PRIOR AUTHORIZATION NUMBER **(MDHHS USE ONLY)**

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

2. INDICATE IF THIS REQUEST IS: ☐ INITIAL ☐ RENEWAL ☐ INCREASE UNITS ☐ DECREASE UNITS

3. PROVIDER'S NAME (AGENCY NAME, OR INDIVIDUAL'S NAME (IF INDEPENDENT RN/LPN)	4. NPI NUMBER	5. PHONE NUMBER
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		7. FAX NUMBER

8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	9. SEX ☐ M ☐ F	10. BIRTH DATE	11. MIHEALTH CARD NUMBER
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)	13. COUNTY		14. PRIMARY DIAGNOSIS (ICD CODE)

15. OTHER INSURANCE? ☐ YES ☐ NO	16. HEALTH INSURANCE COMPANY NAME	17. GROUP / POLICY NUMBER	18. CERTIFICATE / CONTRACT NUMBER

19. IS BENEFICIARY CURRENTLY HOSPITALIZED? ☐ YES ☐ NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER, DISCHARGE PLANNER BELOW. ANTICIPATED DISCHARGE DATE:

20. HOSPITAL NAME	21. HOSPITAL ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)	22. PHONE NUMBER
23. NAME OF DISCHARGE PLANNER	24. DISCHARGE PLANNER'S PHONE NUMBER	25. DISCHARGE PLANNER'S FAX NUMBER
26. ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL, MD OR DO)	27. NPI NUMBER	28. PHONE NUMBER
29. PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		30. FAX NUMBER

31. DESCRIPTION OF SERVICE	32. HCPCS/MODIFIER CODE(S)	33. UNITS PER MONTH	34. START DATE	35. END DATE

36. NUMBER OF SIBLINGS	37. DOES ANYONE ELSE RECEIVE PDN SERVICES? ☐ YES ☐ NO	38. IF YES, PROVIDE CHILD'S NAME RECEIVING PDN SERVICES	39. CHILD'S MIHEALTH CARD NUMBER

40. NUMBER OF OTHER INDIVIDUALS IN HOME REQUIRING CARE	41. IS THE BENEFICIARY CURRENTLY IN SCHOOL? ☐ YES ☐ NO	42. IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDE TRAVEL TIME)

43. NUMBER OF CAREGIVERS	44. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY	45. WORK OR ATTEND SCHOOL? ☐ YES ☐ NO	46. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL
	47. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY	48. WORK OR ATTEND SCHOOL? ☐ YES ☐ NO	49. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL

50. IS MORE THAN ONE PDN/PDN AGENCY INVOLVED? ☐ YES ☐ NO	51. NAME OF OTHER PERSON/AGENCY	52. NPI NUMBER	53. PHONE NUMBER
			54. FAX NUMBER

55. WHO WILL BE MANAGING THE PDN CARE PLAN?	56. PHONE NUMBER (IF DIFFERENT THAN #5 ABOVE)

57. OTHER THAN PDN, DOES THE BENEFICIARY RECEIVE OTHER SERVICES IN THE HOME? ☐ **YES** ☐ **NO** IF YES, LIST OTHER SERVICES IN THE HOME:

58. CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR AUTHORIZATION FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR AUTHORIZATION AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF AUTHORIZED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. **I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW. PROVIDER CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.**

PROVIDER'S SIGNATURE DATE

59. PARENT/GUARDIAN OF BENEFICIARY CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.

PARENT/GUARDIAN SIGNATURE DATE

MDHHS USE ONLY

60. REVIEW ACTION:
APPROVED ☐ INSUFFICIENT DATA ☐
DENIED ☐ NO ACTION ☐
APPROVED AS AMENDED ☐

CONSULTANT SIGNATURE DATE

MDHHS-5405, PROVIDER ELECTRONIC SIGNATURE AGREEMENT COVER SHEET

Michigan Department of Health and Human Services (MDHHS)
(Revised 4-23)

SECTION 1 - INSTRUCTIONS

- Provider should retain a COPY in the office
- MUST be submitted with DCH-1401, Electronic Signature Agreement.

Mail to:
Michigan Department of Health and Human Services
Provider Enrollment Section
PO Box 30238
Lansing, MI 48909

Fax: 517-241-8233

Email to:
MDHHS-DomainRequests@michigan.gov

SECTION 2 – REASON FOR SUBMISSION (check all that apply)

☐ Revalidation

☐ Domain Access ☐ Organization ☐ Individual ☐ Both

☐ Domain Administrator Contact Information

☐ New Tax ID/SSN (List Provider Enrollment staff contact name)

☐ Other (list reason)

SECTION 3 – CONTACT INFORMATION (REQUIRED)

Name	Email Address	Phone Number
MILogin User ID	Provider's NPI Number	Provider's Date of Birth
Provider's Address	City	State Zip Code

SECTION 4 – PROVIDER ENROLLMENT OFFICE USE ONLY

☐ Provided Domain Administrator contact information
☐ Sent/Gave to team lead for processing
☐ Sent to processor with W-9 attached
☐ Opened for revalidation

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy.

AUTHORITY: 42 CFR 455.104
COMPLETION: Voluntary but required for access to CHAMPS.

MDHHS
Michigan Department of Health & Human Services

Provision of Low Vision Services and Aids Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Vision Services Approval/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

_____

_____

_____

_____

_____

2. Present spectacle correction:

R _____ **VA** _____ **ADD** _____ **VA** _____

L _____ **VA** _____ **ADD** _____ **VA** _____

3. Contact Lenses: (If worn)

Power R _____ Type R _____

Power L _____ Type L _____

4. Low vision aids presently in use:

Magnifiers: _____
Microscopics: _____
Telescopics: _____
Loupes: _____
Electronic Projection Magnifier: _____
Filers/typoscopes/visors: _____
Other: _____

5. Relevant Systemic Conditions:

_____

_____

_____

_____

_____

B. BENEFICIARY'S GOALS

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):

R _____ **L** _____

2. Vision Impairment Diagnosis:

R _____ **L** _____

3. Nature and Extent of Visual Fields:

4. Specifications of best conventional spectacle correction:

At distance	**R**	_____	**VA**	_____
	L	_____	**VA**	_____
At near	**R**	_____	**VA**	_____
	L	_____	**VA**	_____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):

☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ 12 Months

2. Referral for medical and/or surgical treatment:

3. Description of Recommended Low Vision Aids:

A. VA **R** **L**	
Description, manufacturer and catalog number	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA **R**_____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA **R**_____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

_____

_____

_____

_____

_____

F. PROGNOSIS

_____

_____

_____

_____

Signature of Examiner _____

Examiner (Print) _____ **Date** _____

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Michigan Department of Health and Human Services

RECUPERATIVE CARE (RC) PRIOR AUTHORIZATION (PA) REQUEST DATA FORM

Contact the Program Review Division Recuperative Care Phone Line: 844-732-8764.

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

This form must be retained in the beneficiary record.

1. Requesting RC Provider Name (Organization/Group)	2. Requesting RC Provider NPI
3. RC Facility Street Address City State ZIP Code	
4. RC Provider Office Contact Information Name: Phone Number: ( ) - Email	

5. Beneficiary Name (Last, First, Middle Initial)	6. mihealth Card Number	7. Date of Birth / /

8. Sex ☐ M ☐ F	9. Beneficiary Phone Number ( ) -	10. Beneficiary Homeless Management Information System Number

11. Beneficiary is currently enrolled in: ☐ Medicaid Fee-for-Service (FFS) only* ☐ Medicaid Health Plan**

12. Discharging Hospital Name: NPI:	13. Discharging Hospital Location (City)	14. Hospital Admission Date / /	15. Hospital Discharge Date / / ☐ Anticipated ☐ Confirmed

16. RC Facility Admission Date / / ☐ Anticipated ☐ Confirmed	17. RC Facility Anticipated Discharge Date / /

18**. Beneficiary is homeless as defined by Housing and Urban Development, homeless category 1, literally homeless (§ 578.3).** ☐ Yes ☐ No

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual:

- ☐ Has a primary nighttime residence that is a public or private place not meant for human habitation; or
- ☐ Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
- ☐ Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

19**. Based on medical record documentation including, but not limited to,:** Most recent history and physical examination, hospital consultation reports, emergency department notes (if applicable), most recent updated plan of care (POC) signed and dated by the ordering/managing physician, most recent signed and dated nursing assessment including a summary of the beneficiary's current status compared to their baseline status and completed by a registered nurse, hospital discharge plan (completed within 2 days of this PA request) including anticipated discharge orders for services such as medical follow-up, durable medical equipment/supplies, and medications, this beneficiary is:

- Discharging from an inpatient hospital admission for an acute condition that can be addressed in less than 90 days. ☐ Yes ☐ No

- Medically stable upon discharge from inpatient hospital stay. ☐ Yes ☐ No
- At risk for re-hospitalization or severe complications without the support of recuperative care services. ☐ Yes ☐ No
- NOT eligible for continued hospital admission, nursing facility, inpatient behavioral health, inpatient psychiatric, or other inpatient services. ☐ Yes ☐ No

20. **Based on Physical Therapy and/or Occupational Therapy assessment** conducted during current hospitalization, including a summary of the beneficiary's current functional status or level of functional independence with ADLs, DME and medication management, this beneficiary is:

- Independently mobile. ☐ Yes ☐ No
- Able to complete ADLs (such as transfers, bed mobility, eating, toileting, etc.) without physical assistance, cueing, or supervision. ☐ Yes ☐ No
- Able to manage any medications independently. ☐ Yes ☐ No
- Able to manage any durable medical equipment/supplies independently. ☐ Yes ☐ No

21. **Based on Social Work notes/assessment**, other consultations, and medical record documentation conducted during current hospitalization:

- Beneficiary has a need for case management and supportive services. ☐ Yes ☐ No

22. **FFS Prior Authorization is required for all Medicaid beneficiaries.**

☐ *Medicaid FFS-only beneficiary requires PA for: **G9002 Care Coordination** and **S9976 Room & Board**

☐ **Medicaid Health Plan enrollee requires PA for: **S9976 Room & Board** (Care Coordination is covered by the MHP.)

23. **<u>PA Determination</u>: Contacted the Program Review Division Recuperative Care Phone Line on / / with the following result:**

☐ Approval issued.
Authorization # _____

☐ Denial issued.
Tracking # _____

☐ Unable to issue a determination at this time due to incomplete information. Tracking # _____

☐ Beneficiary not eligible. Tracking # _____

24. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Signature: Date:

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable program is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

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REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

Michigan Department of Health and Human Services

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident	Medicaid ID Number
Facility Contact	Facility Telephone Number – –
Facility Name	Facility Fax Number – –
Facility Address	

The basis for this request is:

☐ I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)

☐ I believe a single room is not medically necessary, but is needed for the following reason(s):

_____

_____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: $ _____ per day

Single room rate: $ _____ per day

Printed Name of Requestor	Telephone Number – –
Address	Relationship to Beneficiary/Resident

Signature of Requester	Date

MAIL TO: Long Term Care Policy Section
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-7979

FAX TO: 517-241-0066

Note: If no response is received within 10 working days, contact 517-241-4079.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

DCH-0078, REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

Michigan Department of Health and Human Services
(Revised 3-22)

SECTION 1 – REQUEST TO (Select one)

☐ Add ☐ Terminate ☐ Change

SECTION 2 – MEDICAID PROVIDER/MEDICAID HEALTH PLAN/LHD/MDHHS CASEWORKER INFORMATION *

Requester Name			Date
County/Local Health Department	Phone Number	Fax Number	Case Number (if available)

SECTION 3 – LIST OF BENEFICIARIES/CLIENTS TO ADD, TERMINATE OR CHANGE INSURANCE *

Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID
Beneficiary/Client Name	Date of Birth	miHealth ID

SECTION 4 – POLICYHOLDER INFORMATION *

Policyholder Name (Last, First, Middle)		Date of Birth
Employer Name	Social Security Number	Employer City and State

Type of Coverage (Select one)

☐ Traditional ☐ Managed Care (Preferred Provider Organization, Health Maintenance Organization, Point of Service)

Health Insurance Company Name	Group/Policy Number	Certificate/Contract Number
Pharmacy Insurance Name	Dental Insurance Name	Vision Insurance Name

SECTION 5 – REASON FOR CHANGE

☐ Divorce Date of Divorce

☐ Coverage Termination	Date of Termination
☐ Military Discharge	Date of Discharge
☐ Employment Termination	Date of Termination
☐ Other (explain) Date of Change Reason	

Attachments: Attach documentation to substantiate a request to terminate or change insurance coverage, such as a letter from an insurance company or employer.

Comments

Submit

MDHHS-Third Party Liability Division
Fax: 517-346-9817

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AUTHORITY: Title V and Title XIX of the Social Security Act **COMPLETION:** Is voluntary.

COMPLETE INSTRUCTIONS FOR DCH-0078, REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

DCH-0078 is a formal request for change in other insurance status and must be submitted by the Medicaid provider, Medicaid Health Plan, Local Health Department or the Michigan Department of Health and Human Services caseworker to add, terminate, or change beneficiary insurance information other than Medicaid.

INSTRUCTIONS:

To add, terminate or change other insurance on-line, visit https://www.Michigan.gov/ReportTPL to access the form and instructions.

To submit the form via fax or mail:

- PRINT or TYPE to complete the form
- Place a check mark in the appropriate "Add," "Terminate," or "Change" field
- Sections denoted by * are mandatory to be completed
- Attach clear copy of insurance card (front and back) when adding insurance (if available)
- Retain a COPY in beneficiary file
- Submit form and applicable attachments
  via: Fax Number: 517-346-9817

Mail to:

Michigan Department of Health and Human Services
Third Party Liability Division
Bureau of Medicaid Policy, Operations & Actuarial Services
PO Box 30479
Lansing MI 48909

Allow 7-10 business days for the request to be completed. To verify the request has been completed, view the beneficiary eligibility information in the Community Health Automated Medicaid Processing System (CHAMPS).

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.
AUTHORITY: Title V and Title XIX of the Social Security Act **COMPLETION:** Is voluntary.

SAMPLE NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient) (Date of Notice)
(Address)
(City, State, Zip)

(Medical Record Number)
(Beneficiary Number)
(Attending Physician's Name)
(Admission Date)

Dear (Name of Patient)

SUBJECT: CONTINUED STAY NOTICE OF NON-COVERAGE

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or certain services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

The Utilization Review Committee of (Name of Hospital) has reviewed the medical services you have received for (Specify services or condition) from (Date of Admission) to (Date of Notice). The Review Committee has determined that your continued stay in an acute care hospital is not medically necessary, and the medical services you are receiving for (Specify services or condition) could be safely rendered in another less costly setting. You should discuss with your attending physician the arrangements for the health care you may require.

You will not be responsible for payment of the services which are rendered by this hospital from (Date of Admission) through the date you receive this notice, except for payment of deductible, coinsurance, or any convenience services or items not covered by Medicaid. If you decide to stay in the hospital, you will be responsible for payment of all services provided to you by this hospital beginning the day after you receive this notice.

For example: If you receive this notice on _____ you will be responsible for payment of services provided beginning_____.

MDHHS Program Review Division reviews on behalf of the patient or his/her physician any hospital care denied to Medicaid patients in the State of Michigan.

If you disagree with this decision and you remain in the hospital, you or your representative may request an immediate review by MDHHS Program Review Division. You may request this by calling:

MDHHS Program Review Division, PACER Program
Toll Free Telephone Number: 1-844-PACERMI (1-844-722-3764)

cc: MDHHS Program Review Division - PACER Program

"SAMPLE"
NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient) (Date of Notice)
(Address)
(City, State, Zip)

(Medical Record Number)
(Beneficiary Medicaid Number)
(Attending Physician's Name)
(Admission Date – *if applicable*)

Subject: NOTICE OF NON-COVERAGE FOR INPATIENT HOSPITAL ADMISSION

Dear (Name of Patient):

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or inpatient services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

NOTICE OF NON-COVERAGE

(Name of Hospital) Utilization Review (UR) Committee has reviewed your physician's request for your hospital admission. The request has been denied. The hospital's UR Committee has determined that your admission to (Name of Hospital) for treatment of (Specify services or condition) is either: 1) not medically necessary, or 2) that the medical services you may require for the treatment of your condition can be safely rendered in another less costly setting. You should discuss arrangements for any health care treatment you may require with your physician.

APPEAL RIGHTS

MDHHS Program Review Division reviews on behalf of the patient or his/her physician any hospital care denied to Medicaid patients in the State of Michigan.

If you disagree with this decision and you remain in the hospital, you or your representative may request an immediate review by MDHHS Program Review Division. You may request this by calling:

MDHHS Program Review Division, PACER Program
Toll Free Telephone Number: 1-844-PACERMI (1-844-722-3764)

If MDHHS Program Review Division confirms the hospital's initial decision, you will be notified in writing of this decision. If you decide to proceed with the admission to the hospital, you will be responsible for the payment of all services provided to you by the hospital beginning with the date of admission.

If MDHHS Program Review Division overturns the hospital's decision, you will also be notified in writing of this decision. The hospital will contact your physician and make arrangements for your admission to the hospital. Medicaid will cover the cost of your hospital stay except for the payment of any deductible, coinsurance, or convenience services or items not covered by Medicaid.

cc: MDHHS Program Review Division - PACER Program

Maternal Infant Health Program Provider and Medicaid Health Plan Care Coordination Agreement

This agreement is made and entered into this _____ day of _____, in the year _____ by and between _____ (Medicaid Health Plan) and _____ (Maternal Infant Health Program provider).

A. Legal Basis

Whereas, in order to expand enrollment, the Michigan Department of Health and Human Services (MDHHS) has established a competitive bid process that has resulted in contracts with Medicaid Health Plans (MHPs) that are deemed to be qualified to provide specified health care services to Medicaid beneficiaries; and

Whereas, Medicaid-covered maternal and infant health services will be provided through arrangements between MDHHS, MDHHS contracted MHPs, and selected Maternal Infant Health Program (MIHP) providers.

Now, therefore, the MHP and the MIHP provider agree as follows:

B. Terms of Agreement

This agreement will be effective _____ in the year _____. This agreement will be subject to amendment due to changes in the contract between MDHHS and the MHP or changes to the MIHP Medicaid policy certification requirements.

This agreement is effective upon execution and will continue for the length of MHP and MDHHS contract period. Either party may cancel this agreement for cause upon 30 days written notice. Reasons for cause include: breach of duty or obligation; fraud or abuse; federal or state sanctions; and failure to comply with state law or rules the Medicaid Provider Manual, or the MIHP Operations Guide. The terminating party is required to notify MDHHS at least 30 days prior to termination. This agreement will automatically terminate when an MIHP provider fails to maintain the certification requirements of MDHHS.

Once a signed agreement is obtained from both parties, the provisions of this agreement will be extended for a timeframe consistent with the MHP and MDHHS contract period, and the MIHP provider maintaining certification with MDHHS. Either party may cancel this agreement upon 30 days written notice. MDHHS must be notified of the termination of this agreement.

C. Purpose, Administration and Point of Authority

MIHP services are home-visiting preventive services provided to pregnant women, mothers, and their infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. These support services are to be provided by a multidisciplinary team of health care professionals consisting of a qualified licensed registered nurse, licensed social worker and, if available, a registered dietitian and/or infant mental health specialist.

MIHP services are intended to supplement regular prenatal/infant care and to assist physicians (MD, DO), certified nurse midwives (CNMs), and nurse practitioners (NPs) contracted with MHPs. In compliance with MIHP and MHP guidelines, MIHP providers are to coordinate care with medical care providers, mental health providers, and the MHPs, as well as assist in the coordination of transportation services as needed for health care, support services and pregnancy-related appointments.

MDHHS/MHP Contracts and MHP/MIHP Care Coordination Agreements will be available for review upon request by MDHHS. The intent of the Care Coordination Agreement is to explicitly describe the services to be coordinated and the essential aspects of collaboration between the MHP and the MIHP provider.

The MHP shall designate in writing to the MIHP provider the person who has authority to administer this agreement. The MIHP provider shall designate in writing to the MHP the person who has authority to administer this agreement.

D. Areas of Responsibility

Mutually Served Consumers

Mutually served consumers refers to MHP beneficiaries who also qualify for MIHP services. All pregnant and infant Medicaid beneficiaries may qualify for MIHP services. The intent of establishing written procedures between the MHP and the MIHP provider is to assure service coordination and continuity of care for persons receiving services from both entities.

Services to be Provided by the MHP

The MHP will provide Medicaid covered services to Medicaid beneficiaries as required by the MHP contract with MDHHS. MIHP services are voluntary. Beneficiaries may refuse MIHP services at any time.

The MHP will notify all Medicaid beneficiaries enrolled in the MHP of the availability of MIHP services at the time of enrollment. The MHP shall provide a referral for MIHP services for those pregnant and infant Medicaid beneficiaries who are not currently receiving MIHP services or receiving equivalent maternal or infant support services from an evidence-based home visiting program. Referrals can be made in person, by letter, email, fax, or telephone.

Services to be Provided by the MIHP Provider

The MIHP provider will provide the following services:

- Psychosocial and nutritional screening and assessment;
- Plan of care development;
- Professional intervention services by a multidisciplinary team consisting of a qualified licensed registered nurse and licensed social worker and, when available, a registered dietitian and/or an infant mental health specialist;
- Coordination with the MHP for transportation services as needed for health care, substance use disorder treatment, support services, oral health services, and/or pregnancy-related appointments.
- Referral to community services (e.g. mental health, substance use disorder);
- Referral to or provision of childbirth or parenting education classes;
- Coordination with medical care providers; and
- Coordination with the MHP.

MIHP providers will bill and receive reimbursement for MIHP services provided to MHP members as noted in the provider contract established with the applicable MHP.

E. Medical Coordination

Both parties agree to establish a process for clinical staff to communicate on a regular basis to review the care coordination plans and status of mutually served beneficiaries in accordance with applicable privacy laws such as HIPAA, the Mental Health Code and 42 CFR Part 2. This may involve the sharing of written documents and verbal reports. Both parties will collaborate on development of referral procedures and effective means of communicating the need for individual referrals. The MIHP provider will provide the MHP with names of MHP beneficiaries receiving MIHP services on a regular basis, utilizing a standardized form. Communication may include assessment/screening results, the plan of care, and discharge summaries upon request.

The MIHP and MHP will accept and use the MDHHS behavioral health consent form (Consent to Share Behavioral Health Information form [MDHHS-5515]) to disclose medical information protected under the Mental Health Code or substance use disorder information under 42 CFR Part 2.

F. Grievance and Appeals

MIHP providers and MHPs are required to establish internal processes for resolution of grievances and appeals from Medicaid beneficiaries. Medicaid beneficiaries may file a grievance or appeal on any aspect of service provided to them by the MIHP or the MHP in accordance with MIHP and MHP grievance and appeal policies.

The MIHP provider is required to direct beneficiaries to the MHP's grievance and appeal process as appropriate. The MHP is required to direct beneficiaries to the MIHP provider's grievance and appeal process as appropriate.

Both parties will participate in grievance and appeal policies and shall cooperate in identifying, processing, and promptly resolving all grievances and appeals. Both parties are responsible for informing the other about their grievance and appeal process.

G. Dispute Resolution

Both parties agree to participate in a dispute resolution process in the event that the MHP or the MIHP provider contests a decision or action by the other party related to the terms of this agreement.

The dispute resolution process should include:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to MDHHS regarding a disputed decision by an MHP, or for a disputed decision by an MIHP provider.

H. Transportation

The MHP and the MIHP provider each have specific requirements for coordinating transportation services for Medicaid beneficiaries. These responsibilities are outlined in the MHP contract with MDHHS, the contract between the MIHP and the MHP and in the Maternal Infant Health Program Chapter of the Medicaid Provider Manual.

The MIHP provider may coordinate transportation in accordance with the established MIHP/MHP provider agreement or refer the Medicaid beneficiary to utilize the MHP transportation benefit to access MHP covered services, substance use disorder treatment, oral health services, support services and/or pregnancy-related appointments.

Transportation must be arranged and provided within a reasonable timeframe to meet the needs of the beneficiary. The provision or arrangement of transportation may not be delayed due to disagreements between the MIHP and MHP regarding financial responsibility for transportation. Disputes as to payment of transportation services may be handled through the dispute resolution process.

I. Quality Improvement

Both parties agree to have mechanisms in place to conduct Quality Improvement activities to monitor the coordination of services. The MIHP provider and the MHP shall participate in quality improvement programs and shall cooperate in conducting reviews and audits of care.

J. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state and local laws, regulations, guidelines, and directives.

K. Signatures

Maternal Infant Health Program Provider	**Medicaid Health Plan**
_____	_____
Signature	Signature
_____	_____
Title	Title
_____	_____
Date	Date
_____	_____
Business Address	Business Address
_____	_____
Business Telephone	Business Telephone

Billing Provider NPI: 1111111111 **Name**: Example O. Provider **EIN/TIN**: 010101010 **Vendor ID**: XX0000000 **Pay Cycle**: XX **RA Number**: 78176112 **RA Date**: 10/12/2017

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	$0.00		$0.00

CLAIM SUMMARY

Category	Count
Paid	64
Credited	0
Denied	29
GA	0

Total Approved	$261,244.79	Total Adjusted	$0.00	Total Paid	$261,244.79

Warrant/EFT #: 000032295 Warrant/EFT Date: 10/12/2017

RA Sample

1642718380000003

Billing Provider NPI: 1111111111 **Name**: Example O. Provider **EIN/TIN**: 010101010 **Vendor ID**: XX0000000 **Pay Cycle**: XX **RA Number**: 78176112 **RA Date**: 10/12/2017

Gross Adj ID Beneficiary Name Beneficiary ID Patient Account # Medical Record #	Original TCN TCN Type of Bill	Submitter ID Rendering Provider NPI	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount	Category	Reason	Remark
Patient, One XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	09/27/2017 07/31/2017-07/31/2017				$4,605.51	$0.00	D		MA32
	XXXXXXXXXXXXXXX		-	0022		1	$0.00	$0.00	D		N522, N56
	XXXXXXXXXXXXXXX		07/31/2017-07/31/2017	0130		1	$760.00	$0.00	D	B7	M53, N522
	XXXXXXXXXXXXXXX		-	0250		7	$394.06	$0.00	D	B7	N522
	XXXXXXXXXXXXXXX		-	0270		1	$103.19	$0.00	D	B7	N522
	XXXXXXXXXXXXXXX		-	0410		0	$3,969.00	$0.00	D	B7	N522
Patient, Two XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	12901	09/27/2017 08/01/2017-08/31/2017				$13,129.74	$0.00	D		
	XXXXXXXXXXXXXXX		-	0022		13	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0022		8	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0022		10	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0130		13	$9,880.00	$0.00	D	B7	
	XXXXXXXXXXXXXXX		-	0130		8	$6,080.00	$0.00	D	B7	
	XXXXXXXXXXXXXXX		-	0130		10	$7,600.00	$0.00	D	B7	N362
	XXXXXXXXXXXXXXX		-	0430		68	$2,505.67	$0.00	D	B7	N301, N674
	XXXXXXXXXXXXXXX		-	0434		1	$99.65	$0.00	D	B7	N301, N674
Patient, Three XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				$7,650.00	$5,532.10	P		N48
	XXXXXXXXXXXXXXX		09/01/2017-09/30/2017	0120		30	$7,650.00	$5,532.10	P	142, 45	
Patient, Four XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				$7,650.00	$4,690.10	P		

RA sample

1642718380000004

SAMPLE

Notification of Upcoming End Date for Electronic Visit Verification
Live-In Caregiver Attestation Documentation Letter

Dear <live-in caregiver's first and last name>

You are receiving this letter because your live-in caregiver exemption is set to end on <end date>. According to Michigan Medicaid policy for electronic visit verification (EVV), the live-in status must be renewed at least annually.

If you are still living with <enter beneficiary's first and last name> and want to keep the exemption from electronic visit verification (EVV), you must complete and submit another Live-In Caregiver Attestation form, BPHASA-2421, no later than <enter due date (the end date of the existing Attestation>. In the "Purpose of Attestation" area on the form, check the box for "Renewal." If there has not been a change of address from the approved Attestation form on file, no additional documentation for proof of address is needed for the renewal.

If there has been a change in the existing address on file, new proof of address documentation is needed (see BPHASA-2421 instructions page for a list of acceptable documentations).

Once the BPHASA-2421 Attestation form is complete with documentation (if needed), submit it to:

<enter Approving Entity's information>

Sincerely,

<enter Approving Entity signature>

Michigan Department of Health and Human Services

Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled DME, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers.

MDHHS requests that the MSA-1653-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 12	Check Yes if beneficiary is in a Nursing Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Facility name, address and phone number.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 25	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 26	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 28	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS – Behavioral and Physical Health and Aging Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS – Behavioral and Physical Health and Aging Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

Michigan Department of Health and Human Services

SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	3. NPI NUMBER	4. PHONE NUMBER
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER

7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER

11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)
12. DOES BENEFICIARY RESIDE IN A NURSING FACILITY? ☐ **YES** ☐ **NO** **IF YES, PROVIDE** FACILITY NAME, ADDRESS, PHONE NUMBER.

13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	14. NPI NUMBER	15. PHONE NUMBER
16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		17. FAX NUMBER

18. LINE NO.	19. BRAND NAME, MODEL CATALOG OR PART NUMBER	20. DESCRIPTION OF SERVICE	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01						
02						
03						
04						
05						
06						
07						

25. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

27. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

28. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE DATE

MDHHS USE ONLY

29. REVIEW ACTION:				30. CONSULTANT REMARKS
APPROVED	☐	RETURN	☐	
DENIED	☐	NO ACTION	☐	
APPROVED AS AMENDED ☐				

CONSULTANT SIGNATURE DATE

DCH-0893, VISION SERVICES APPROVAL/ORDER

Michigan Department of Health and Human Services
(Revised 3-22)

THE PROVIDER IS RESPONSIBLE FOR ELIGIBILITY VERIFICATION. APPROVAL DOES NOT GUARANTEE BENEFICIARY ELIGIBILITY OR PAYMENT

SECTION 1 – MDHHS USE ONLY

1. Prior Authorization Number (MDHHS Use Only)

SECTION 2 – ORDERING PROVIDER

2. Ordering Provider Name (Last, First, Middle Initial)

3. Ordering Provider NPI Number	4. Date of Order (MM/DD/YYYY)		
5. Address (No. & Street, Suite, etc.)	City	State	Zip Code
6. Provider Fax Number	7. Provider Phone Number		

SECTION 3 – PRESCRIBING PROVIDER

8. Individual Prescribing Provider Name (Last, First, Middle Initial)

9. Individual Prescribing Provider NPI Number

10. Ordering Provider Certification

The patient named below (parent or guardian if applicable) understands the necessity to request vision services and/or prior approval for the vision services indicated. I understand that services requested herein may require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may lead to prosecution under applicable Federal and State law.

Ordering Provider Signature

SECTION 4 – BENEFICIARY INFORMATION

11. Beneficiary Name (Last, First, Middle Initial)	12. Birth Date	13. mihealth Card Number
14. Beneficiary Address (No. & Street, Apt./Lot #, City, State, Zip Code)	15. Sex ☐ Male ☐ Female	16. ICD Diagnosis Code

SECTION 5 – SERVICES AND MATERIALS REQUESTED

	17. Description of Service(S)	R	L
01		☐	☐
02		☐	☐
03		☐	☐
04		☐	☐
05		☐	☐
06		☐	☐
07		☐	☐

18. Procedure Code	19. Modifier	20. Quantity	21. Charge

Note: If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Provider Manual.

SECTION 6 – TYPE/STYLE OF LENS(ES) AND FRAMES REQUESTED

22. Lens Type

☐ Plastic ☐ Glass ☐ Polycarbonate ☐ Lens(es) Only ☐ Frame Only

23. Lens Style

☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Hi Index ☐ Cataract

24. Frame Name C-Size Manufacturer

Color Eye Size Bridge Size Temple Style & Length

SECTION 7

25. Lens Specifications

	Sphere	Cylinder	AXIS	Prism Power & Base Direction	MRP Horizontal	MRP Height
R						
L						

	Add	Segment Height	Width & Style	Segment Inset	Total Inset	PD
R						Far
L						Near

26. Special Instructions to Laboratory

27. Previous Lens Specifications

	Sphere	Cylinder	AXIS	Add	Prism/ Direction	Lens Style
R						
L						

SECTION 9 – MDHHS USE ONLY

28. Review Action

☐ Approved ☐ Insufficient Data ☐ Approved as Amended ☐ Denied ☐ No Action

29. Consultant Comments Initials and Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

DCH-0893, VISION SERVICES APPROVAL/ORDER INSTRUCTIONS

GENERAL INSTRUCTIONS

The DCH-0893 must be used by Medicaid enrolled vision providers to request Prior Approval (PA) and/or order optical hardware for vision services. MDHHS requests that the DCH-0893 be typewritten to facilitate processing. A fill-in enabled copy of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary. The form is generally self-explanatory. The following instructions are to assist in completing the DCH-0893.

Note

- If prior authorization is required, attach documentation of medical necessity and the detailed training plan (if applicable) pursuant to the Medicaid Provider Manual.
- If applicable, complete and attach form MSA-0891, Provision of Low Vision Services and Aids Support Documentation.
- If applicable, complete and attach form MSA-0892, Documentation of Medical Necessity for the Provision of Contact Lenses.

Items	Instructions
1	MDHHS use only
2 – 3	Related to the ordering provider.
4	Provide the date the service and/or hardware is being ordered.
5 – 7	Related to the ordering provider
8 – 9	Related to the prescribing provider
10	Ordering Provider Signature requires a hand-written signature (i.e., a stamped signature is unacceptable).
11 – 15	Beneficiary information which can be obtained from the mihealth card or, for Children's Special Health Care Services (CSHCS) enrollees, from the Client Eligibility Notice.
16	The diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases (ICD). If appropriate, each eye's diagnosis(es) must be included.
17 – 21	Relate to services and materials being requested and applicable charges. • Lines 01 through 07 are available for lenses, frames, and/or special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. • Item 18 (Procedure Code) must reflect the appropriate CPT/HCPCS procedure code. • Item 19 (Modifier) must reflect a valid modifier applicable for the listed procedure code. • Item 20 (Quantity) must reflect the appropriate quantity for each procedure code. Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2." • Item 21 (Charge) is completed only **for items without fee screens requiring prior approval.** Enter your usual and customary charge.
22 – 24	Relate to the type/style of lens(es) and frame requested.
25	Enter all lens specifications. The width and style must be consistent with the procedure code appearing in Item 18.
26	Additional instructions to the vision contractor necessary for proper fabrication.

27 Specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. **Note:** The only time this item is left blank is for initial spectacles.

28 – 29 MDHHS use only.

SUBMISSION INSTRUCTIONS

Prior Approvals (PA) requests should be received by the MDHHS Vision Contract Manager no more than 30 calendar days from the date of order. If received beyond 30 days, the provider must include a detailed explanation of why the form submission was delayed.

The provider should retain a copy of the completed form for their file and mail or fax the DCH-0893 to:

MDHHS Vision Contract Manager
Program Review Division
PO Box 30170
Lansing, MI 48909

Fax: 517-335-0075

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

Optical Hardware Order - Orders placed with the vision contractor must be received no more than 30 calendar days after the date of order. If beyond the 30 days, the contractor will return the order to the provider who must explain to the Medicaid Program Review Division why the form submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and submit the DCH-0893 to:

Classic Optical Laboratories
3710 Belmont Avenue
PO Box 1341
Youngstown, OH 44501-1341

Telephone: 888-522-2020
Fax: 888-522-2022
Online Address: http://www.classicoptical.com

Note: Optical hardware orders may also be submitted through an online process with the vision contractor. To utilize on-line submission, contact Classic Optical Laboratories for additional information.